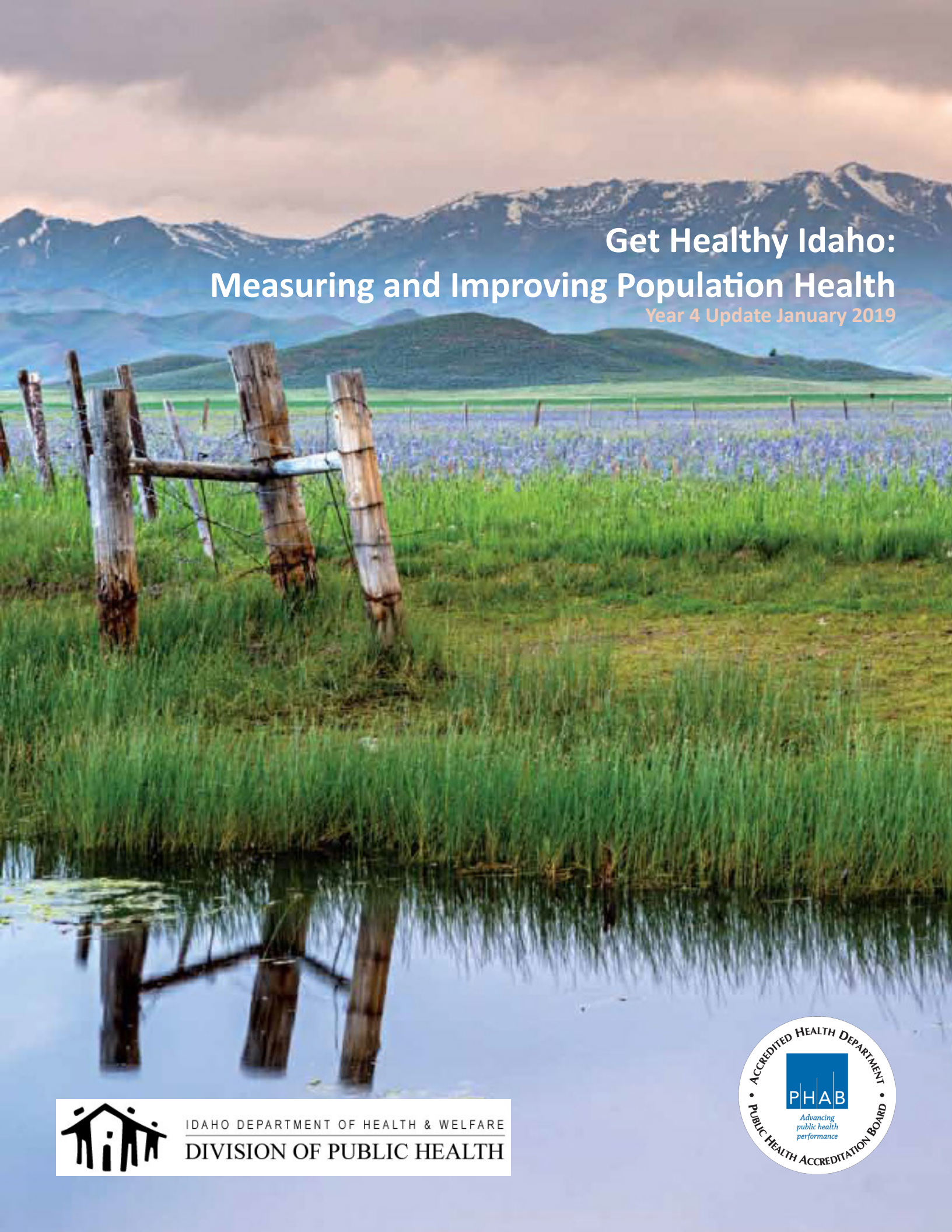

Get Healthy Idaho: Measuring and Improving Population Health

Year 4 Update January 2019

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

ACCREDITED HEALTH DEPARTMENT • PUBLIC HEALTH ACCREDITATION BOARD •
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Advancing public health performance

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Message from the State Health Official

Welcome to *Get Healthy Idaho: Measuring and Improving Population Health! Get Healthy Idaho* consists of two integral parts: an annual plan to improve population health and an assessment of the current state of the health of Idahoans. *Get Healthy Idaho* is a five-year plan and includes annual progress on the plan objectives. The 2019 plan priorities remain:

1. Access to Healthcare
2. Diabetes
3. Tobacco
4. Obesity

The *Get Healthy Idaho* assessment is a comprehensive review of the health of Idahoans. This information provides the foundation for understanding the health of our residents and communities. In the 2019 plan you will see updated data tables, as well as new data collected from partners across the state. While the assessment highlights areas of particular concern, it also provides insight into the assets that exist across the state and within communities that can be used to address some of the areas of opportunities.

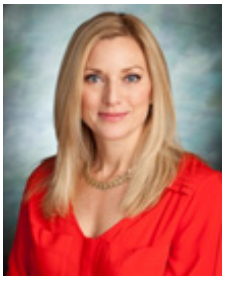
The Idaho Leading Health Indicators form the framework of *Get Healthy Idaho.* Idaho's Leading Health Indicators focus our work and assure that a population health perspective is maintained that spans the life course.

Get Healthy Idaho is a key element in the Division's achievement of 5-Year accreditation status through the Public Health Accreditation Board. This status was awarded on June 6, 2017.

With the end of the Statewide Healthcare Innovation Plan (SHIP) Model Test Grant in January 2019, you will see some *Get Healthy Idaho* initiatives also come to a close. *Get Healthy Idaho* however, continues to incorporate strategies that shift from traditional clinical based approaches, to innovative patient centered and community-wide approaches. The Division of Public Health makes every effort to integrate and collaborate within the Division and Department, as well as with external partners to maximize positive impacts to population health measures.

The Division of Public Health is committed to the comprehensive, inclusive, transparent, and on-going process of *Get Healthy Idaho* that supports the health of all Idahoans, both current and future. We thank you for your interest in this report and Idaho's future.

An electronic copy of this report, as well as the most current population health data associated with *Get Healthy Idaho,* can be found online at http://gethealthy.dhw.idaho.gov.



In Good Health!

Elke Shaw-Tulloch, MHS
Administrator
Division of Public Health

Introduction

Get Healthy Idaho: Measuring and Improving Population Health is an initiative of the Department of Health and Welfare (DHW), Division of Public Health (DPH) that consists of two integral parts: a statewide, comprehensive population health assessment that provides a foundation for understanding the health of Idahoans and communities; followed by a plan for improving population health that focuses public health efforts to address specific priority areas. The intended outcome of *Get Healthy Idaho* is to improve the health of all Idahoans through broader partnerships to deliver the outlined strategies.

Get Healthy Idaho supports the DPH Strategic Plan's central challenge - to advance the Division's leadership and influence in public health. It supports the identified priority areas of the Strategic Plan to strengthen public health practice and to ensure programmatic excellence. This work satisfies Public Health Accreditation Board (PHAB) standards 1.1 (statewide health assessment) and 5.2 (statewide health improvement plan). *Get Healthy Idaho* is reviewed and updated annually from perspectives of both the data and the identified strategies.

In the spring of 2015, the Population Health Work Group (PHWG) was formed as a workgroup of the Idaho Healthcare Coalition in support of the SHIP Model Test Grant. This group provides oversight and approval of the *Get Healthy Idaho* plan. The PHWG is chaired by the Division of Public Health Administrator, co-chaired by a local public health district director, and consists of leaders from local public health, statewide-community entities, and members of the newly formed Healthcare Transformation Council of Idaho (HTCI).

Get Healthy Idaho aligns with the calendar year. This was a purposeful decision to assure the most current information is available for the annual legislative session and to allow the DPH strategic plan and *Get Healthy Idaho* to have staggered timelines, allowing them to truly inform each other. The most current version of *Get Healthy Idaho* is made available in January of each year through http://gethealthy.dhw.idaho.gov, the DHW website, or in hard copy through DPH Administration.

Advancing Population Health

With the State Healthcare Innovation Plan (SHIP), funded by the Center for Medicare and Medicaid Innovation (CMMI), coming to a close January 31, 2019 the foundation has been laid to for continued innovation in advancing population health. In Idaho, the goal of the SHIP was to redesign the healthcare system, evolving from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes. From the outset, Get Healthy Idaho has been linked to SHIP as the population health improvement plan addressing three SHIP priorities in addition to two others. Get Healthy Idaho has annually tracked progress towards five-year goals, provided data to the seven Regional Health Collaboratives and informed the Governor-appointed Idaho Healthcare Coalition.

As we move into 2019 it is clear the SHIP has served as a catalyst for healthcare transformation in Idaho. The Idaho Healthcare Coalition has evolved into the Healthcare Transformation Council of Idaho (HTCI) with the intent of continuing the systems transformation work, payment reform and support of clinics as they move towards to patient centered medical home (PCMH) certification. Medicaid is implementing their Value Care Program to promote and support clinics as they transform to patient centered medical homes. Community advisory groups called Community Health Outcome Improvement Coalitions (CHOICe) will play an important role in advancing population health within their region through the inclusion of stakeholders outside the traditional hospital and physician model by working in partnership with their Regional Care Collaborative (RCC).

With the development of HTCI, the Division will continue to support the Population Health Work Group to inform population health and bring the social determinants of health into discussions and policy work. Having established an understanding of the Centers for Disease Control and Prevention's (CDC) system for analyzing the measures of health at the patient level, clinic-community level and community-wide level as described below, we will continue to use this model.

Traditional Clinical Approaches – The focus is on an individual and has a patient construct. Typical clinical services done in a one-on-one patient interaction would be at this level.

Innovative Clinical Care – The focus is a patient construct with a narrow population view such as a practice or an accountable care organization. The patient centered medical home is an innovative clinical mode that provides linkages which support patients in the community.

Community-wide Health – The focus is on a broad population, such as a Health District or the state of Idaho, and has a community construct. Community-wide health initiatives typically have a policy focus.

St. Maries, Idaho Middle School STAND grant assists with smoke free ordinance for a local park.
American Lung Association – Support Teens Against Nicotine Dependency (STAND)

The following table defines these three levels of services and includes disease and risk factor examples.

Traditional Clinical Approaches 	**Innovative Clinical Care Patient-Centered Medical Home** 	**Community-wide Health** 
Focused on an individual; patient construct		Focused on a broad population; community construct
Typical clinical services done in a one-on-one patient interaction	Linkages that support patients in the community and that provide services outside the clinical setting	Broader, mostly policy focused aimed at supporting the broad community and the overall health of the population in the community
DIABETES Example		
Screening for pre-diabetes, diagnosis, treatment, medication, clinical guidance, A1C monitoring, eye exam, foot exam	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietitian-Nutritionist referral, dental referral, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; policies to reduce tobacco usage and trans fats in foods
OBESITY Example		
Diagnosis, medication, weight and height to calculate body mass index and monitor, blood pressure, cholesterol screening, physician/patient counseling	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral and cavity risk assessment, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; mandatory changes in school vending and physical education courses
TOBACCO Example		
Screening patients for smoking, ensuring smoking cessation referral, physician/ patient counseling	Linkages that support patients in community or medical-health neighborhood, linking patient to cessation class or quit line	Practices and policies that support lower smoking rates statewide (clean indoor air policies, increasing the legal age of tobacco purchase, tobacco tax increase, etc.)

Get Healthy Idaho

Plan for Improving Population Health, 2019

The results of the 2018 population health assessment support the continued focus on the following four health priorities in 2019:

1. Access to Care
2. Diabetes
3. Tobacco
4. Obesity

The *2019 Get Healthy Idaho: Plan for Improving Population Health* contains goals, objectives, strategies, and measures for each of the above priority areas. The plan, which builds on the first three years, can be found on the following pages (10-17).

A report providing the status of the work completed to date in each priority area can be found beginning on page 73.

Health Priority: ACCESS TO CARE

Five Year Goal: Increase access to healthcare services

SMART Objective(s): Annually assess 100% of Health Professional Shortage Areas due for review

Strategy 1: Review and renew healthcare shortage areas to maximize funding and healthcare provider recruitment efforts in rural and frontier counties.

Activities:
The DPH's Bureau of Rural Health and Primary Care actively collects and analyzes data to support federally-designated Health Professional Shortage Areas in primary care, dental health, and mental health and Medically Underserved Areas/Populations. These designations help improve healthcare access through new and expanded resources.

Measure 1:	Baseline	Annual Target
Number of currently designated areas reviewed annually as dental, mental, primary care Health Professional Shortage Areas	46 per year	46

Strategy 2: Develop and implement virtual patient-centered medical homes (PCMH) through Community Health EMS (CHEMS), community health workers (CHW), and Telehealth (through January 2019).

Activities:
The DPH's Bureau of Rural Health and Primary Care and Bureau of Emergency Medical Services (EMS) and Preparedness provide training, resources, and mentoring to establish new CHEMS programs statewide.

The Bureau of Rural Health and Primary Care also provides access to CHW training as well as resources to establish new telehealth programs.

The CHEMS, CHW, and telehealth programs are designed to extend the reach of primary care in rural, frontier, and underserved communities and are referred to as virtual patient-centered medical homes in SHIP.

Federal grant funds for CHW and CHEMS training will end January 31, 2019.

Measure 1:	Baseline	Target
Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2 (CY2015)	13

Measure 2:	Baseline	Target
Total number of CHWs trained through Idaho State University program	0 (CY2015)	125

Idaho's Challenges and Opportunities: Access to Care

Idaho is the 14th largest state in the nation and 39th in population size with 1,716,943 people based on the 2017 census estimates. The state's per capita income is significantly less than the national average ($24,280 compared to $31,177), while the percentage of persons living in poverty is 14.5% for Idaho compared to the U.S. rate of 14.6%.

The Idaho Department of Commerce defines rural as any county that does not have a population center with 20,000 persons or greater, this definition includes 35 of Idaho's 44 counties. Eighteen of Idaho's 44 counties or approximately 40% are defined as frontier counties (fewer than 6 people per square mile, National Center for Frontier Communities).

Idaho ranks 46th of 50 states with 73 active primary care physicians per 100,000 population according to the Idaho Physician Workforce Profile, well under the national rate of 91 physicians per 100,000 population. The state also ranks 49th of 50 states in active physicians per 100,000 population (State Physician Workforce Data Report, AAMC, 2017). Idaho ranks 50th in the rate of psychiatrists with 5.1 per 100,000 population compared to the national average of 8.9 per 100,000. (American Medical Association Master File, 2017)

Primary Care: There are 43 Health Professional Shortage Area (HPSA) designations for geographic areas and population groups across the state of Idaho. These designations cover 96.4% of the state's total land area.

Dental Health: There are 42 HPSA designations for geographic areas and populations across the state of Idaho. These designations cover a total of 97.0% of the state's land area.

Mental Health: There are seven regional HPSA designations, which encompass all 44 counties, for geographic areas and populations across the state of Idaho. Due to the severe shortage of mental health professionals across the state, the Idaho Primary Care Office reviews the state's geography on a regional basis. These mental health designations encompass 100% of Idaho's land area and population.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase from 51 to 55 the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2019

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education and Training (DSME/T) Programs.

Activities:
The Diabetes Prevention and Control Program (DPCP) works with healthcare systems to increase the number of trained primary care staff who complete the American Association of Diabetes Educators (AADE) Level 2, or comparable AADE diabetes training specific to their position, to enhance diabetes outcomes and promote the benefits of patient participation in ADA/AADE DSMES/T Programs as appropriate. The DPCP also works with providers to develop alternatives location for delivery of DSMES/T and DPPs, which appeals to both patients and referring providers (e.g. churches, community centers, libraries, etc.).

The DPCP is working to assess the number of pharmacies providing DSMES/T and DPP services for people with type 2 diabetes. The results of the assessment will be used to identify agreement opportunities to expand access to DSMES/T and DPP services.

The DPCP works with the DHW media contractor to create and implement a prediabetes marketing plan and campaign to reach Idaho adults who are at high-risk for developing type 2 diabetes.

Measure 1:	Baseline	Annual Target
Number of ADA-recognized/AADE-accredited DSME programs	28 (SFY2015)	42
Measure 2:	Baseline	Target
Number of persons with diabetes who have at least one encounter at an ADA recognized/AADE accredited program.	6,412 (CY2012)	8,400

Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.		
Activities: The DPCP subgrants with the local public health districts to implement a standardized referral processes to DSMES/T and DPPs services. The DPCP subgrants with healthcare systems to establish standardized referral systems for newly diagnosed patients with prediabetes to CDC-recognized or pending recognition DPPs in Idaho. The DPCP subgrants with local DPPs to increase access and awareness of the National Diabetes Prevention Program (NDPP).		
Measure 1:	Baseline	Annual Target
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	320
Measure 2:	Baseline	Target
Number of CDC-recognized or pending recognition DPPs	3 (SFY2015)	15

Idaho's Challenges and Opportunities: Diabetes

Effectively preventing and managing diabetes will help Idahoans lead more productive and healthier lives. An estimated 110,000 Idaho adults, or 9% of the adult population, live with diabetes. CDC estimates that 560,000 Idaho adults, or 35% of the adult population, live with pre-diabetes. Diabetes is the seventh leading cause of death in Idaho, and about one third of Idaho adults living with diabetes do not know they have the disease. The direct medical cost of diagnosed cases of diabetes in Idaho is estimated as more than $172 million annually. Improperly managed diabetes often leads to costly and serious complications and even death. Type 2 diabetes can be prevented or delayed through sustainable lifestyle changes.

Health Priority: TOBACCO USE

Five Year Goal: Reduce tobacco use in Idaho

SMART Objective(s): Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 57.6% to 60.0% by July 2019.*

Strategy 1: Increase referrals to cessation services.

Activities:
The DPH's Women's Health Check Program (WHC) contracts with local public health districts and health systems to provide training at all enrollment sites to ensure WHC clients are assessed for tobacco use annually and are referred to tobacco cessation resources, as appropriate.

Project Filter, Idaho's Tobacco Prevention and Control Program, contracts with the seven local public health districts and three Idaho Tribes to provide technical assistance and training to healthcare providers on Quitline referrals.

Project Filter developed a toolkit to encourage patient referrals to the Idaho Quitline, an evidenced-based cessation service, by healthcare providers and pharmacists.

Note: Quitline services include both telephonic and online services free of charge, including nicotine replacement therapy.

Measure 1:	Baseline	Annual Target
Number of women enrolled in WHC ages 21-64 referred to the QuitLine cessation services. **Note**: Target is lower than baseline due to decreased enrollment for Women's Health Check services.	708 (SFY2014)	700

Measure 2:	Baseline	Annual Target
Number of tobacco users who registered for Idaho QuitLine cessation services.	8,142 (SFY2015)	8,956 (10% above baseline)

Strategy 2: Promote the use of Nicotine Replacement Therapy (NRT) for appropriate individuals enrolled in cessation services.

Activities:
Project Filter developed a healthcare provider "toolkit" with information about referral and cessation resources, including the efficacies of NRT use during a quit attempt. To date, just over 100 toolkits have been distributed to Federally Qualified Health Centers and to private health systems.

Measure 1:	Baseline	Annual Target
Number of Idaho QuitLine registrants shipped at least 4 weeks of NRT	5,943 (SFY2015) (73% of total registrants)	6,717 (75% of target for phone and QuitLine)

Measure 2:	Baseline	Target
Proportion of registrants ordering NRT through Idaho QuitLine cessation services	73% (SFY2015)	75%

*Baseline estimate of 57.6% is based on 2014 Idaho Behavioral Risk Factor Surveillance System (BRFSS) survey. Objective is unmet at time of publication based on results of 2016 Idaho BRFSS survey (52.8%).

Idaho's Challenges and Opportunities: Tobacco Use

Tobacco use is the single most preventable cause of disease, disability and death in the United States, resulting in an estimated 480,000 people dying prematurely from smoking or exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014). Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined. Comprehensive strategies have been identified and proven effective for preventing youth from starting, helping smokers quit, and reducing secondhand smoke exposure, making the fight against tobacco use a winnable battle. High tobacco taxes, smoke-free or tobacco-free policies, well-funded youth prevention programs and regulation of tobacco products are proven ways to reduce death and disease caused by tobacco use. Tobacco use remains the leading preventable cause of death and disease in Idaho. Idaho's most recent (2017) Behavioral Risk Factor Surveillance Survey (BRFSS) indicates the current smoking rate for adults is 14.4%. While this is lower than the national average of 17.1%, there is still work to be done. Data from the 2017 Idaho Youth Risk Behavior Survey (YRBS) show the Idaho youth smoking rate to be 9.1% and that nearly 14.3% of Idaho youth are currently using electronic nicotine delivery systems. The economic burden incurred in Idaho from smoking has reached $508 million in total medical costs ($100.5 million covered by Medicaid) and $433.9 million in lost productivity from premature death each year (CDC, 2014). This amount does not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking. Tobacco use also imposes additional costs such as workplace productivity losses and damage to property. Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, the lesbian, gay, bisexual, transgender (LGBT) community, those of low socio-economic status, those living with mental illness, Medicaid enrollees, and veterans represent Idaho population groups that experience tobacco-related health disparities.

Health Priority: OBESITY

Five Year Goal: Reduce the burden of obesity in Idaho

SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 26% to 25% by December 2019*

Strategy 1: Increase healthy options for infants and children through awareness, education, and collaboration.

Activities:
The DPH's Idaho Physical Activity and Nutrition (IPAN) Program, in collaboration with the Maternal and Child Health (MCH) Section, will pilot the Farm-to-Early Care and Education (ECE) program in a minimum of five childcare facilities in South Central Idaho. A toolkit will be developed including curriculum and activities for classrooms, easy and nutritious recipes, a guide for securing local food source, and a guide for starting a local garden. The pilot will be complete in the Fall of 2019. IPAN will work with the local PHDs to train childcare facilities statewide on the implementation of Farm-to-ECE. IPAN will also explore other national childhood obesity programs for possible implementation in Idaho.

The DPH's Idaho Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program contracts with local entities to provide individual appointments and group classes or group events related to meal planning, cooking skills, healthy eating, and age-appropriate healthy nutrition and physical activity counseling. Idaho implemented online participant nutrition education (WICSmart) statewide Sept. 1, 2018. Expanding the nutrition education options available to WIC families increases the likelihood education will be completed and have a positive impact over time. Supporting staff with training and collaboration further strengthens these efforts. In addition, the Idaho WIC program provides local WIC Programs with the complete series of online learning modules describing baby behaviors which could influence a mother's feeding choice and help her to understand the needs of the baby in regards to stimulation, engagement, disengagement, and development.

During 2019, WIC will implement and utilize the United States Department of Agriculture's (USDA) new National Breastfeeding Promotion and Support Campaign for Millennial WIC Moms. This campaign includes new breastfeeding messaging, materials and resources to promote and support breastfeeding among WIC moms and targeted groups.

Measure 1:	Baseline	3 Year Cumulative Target
Number of childcare facilities participating in the Farm-to-ECE pilot in South Central Idaho	0 (SFY2019)	5
Measure 2:	Baseline	3 Year Cumulative Target
Percentage of children on WIC age 2-5 who are overweight or obese	28.1% (SFY2016)	26%
Measure 4:	Baseline	Target
Percentage of women on WIC who are still breastfeeding at 3 months	53.6% (SFY2016)	55%
Measure 5:	Baseline	Target
Percentage of 3rd grade students who are overweight or obese based on BMI	29.7% (2011-12)	26%

*Baseline estimate of 27.8% is based on 2011/12 National Survey of Children's Health. The objective is currently met based on results of 2016 Idaho National Survey of Children's Health (26.0%). This objective will be tracked through the remainder of the population health improvement plan timeframe (2015-2019).

Youth overweight and obesity is defined on pages 35 and 36
Adult overweight and obesity is defined on pages 37 and 38

Idaho's Opportunities and Challenges: Obesity

Idaho, like most states, is seeing a steady increase in the percentage of its population that is overweight or obese. Overweight and obesity are both labels for ranges of weight that are excessive for a certain height. Due to the difficulty of measuring body fat directly, overweight and obesity are estimated by body mass index (BMI). Adults with a BMI between 25.0 and 29.9 are considered overweight and those with a measure of 30 and greater are considered obese. Childhood and adolescent BMI measures take sex and age into consideration. Most obesity data for adults is self-reported through the BRFSS. According to the 2017 BRFSS, the majority of Idahoans ages 18 and older are considered overweight or obese (65.8%). The breakout is 36.5% overweight and 29.3% obese. Across Idaho, males are more overweight than females (72.7% compared with 58.5%) and more obese than females (30.4% compared with 28.1%). Hispanic adults are more overweight or obese than non-Hispanic adults (72.1% compared with 65.3%). Overall, Idaho children are less overweight or obese than national rates (26.1% vs. 30.4%). The current obesity rate for Idaho High School students is 11.4%. Idaho schools are not required to collect height and weight data or report BMI. During the 2016-2017 school year, the Division's Bureau of Community and Environmental Health (BCEH) conducted the Idaho 3rd Grade BMI Assessment. That assessment found 28.6% of 3rd graders to be overweight or obese. Childhood overweight and obesity rates range from 10 to 50 percent in communities across Idaho. Many of the leading causes of preventable disease and death, including heart disease, stroke, type 2 diabetes and certain types of cancer are obesity related. A 2012 Robert Wood Johnson Foundation Trust for America's Health Report estimated that Idaho spends more than $2.7 billion in costs due to obesity, which are projected to rise to more than $3 billion by 2030. The Report also estimates that a five percent decrease in obesity would save Idaho $1.2 billion by 2020 and $3.3 billion by 2030.

In FY2018, the federal Physical Activity and Nutrition (PAN) non-competitive funding opportunity was replaced by a new competitive five year grant. The State PAN Program applied for these funds but was not awarded. The Program has since expanded its partnership with the State Maternal and Child Health Section to address childhood obesity.

An early and effective intervention to promote the healthy weight of children is breastfeeding. Prolonged breastfeeding has been shown to decrease the risk of overweight in children (http://pediatrics.aappublications.org/content/113/2/e81.short). Breastfeeding longer than six (6) months postpartum provides several health benefits to both the infant and the mother. Typically, during the time period after the birth of the infant up to three (3) months postpartum is when women tend to stop breastfeeding. There are several factors that impact the decision to stop breastfeeding. However, with focused support during this critical period, many women can be encouraged to continue to breastfeed. While Idaho generally has good breastfeeding initiation rates, improving exclusive breastfeeding rates past 3 months can have multiple and long-term benefits for both mothers and children. Continued education and policy efforts physical activity, nutrition, and the built environment will be critical in reducing obesity and improving health across the lifespan. During 2019 WIC will implement and utilize the United States Department of Agriculture's (USDA) new National Breastfeeding Promotion and Support Campaign for Millennial WIC Moms. This campaign includes new breastfeeding messaging, materials and resources to promote and support breastfeeding among WIC moms and targeted groups.

Appendix: 2018 Health Assessment

Idaho Population Health Assessment Summary

Introduction
The DPH's strategic plan illustrates the Division's commitment to advancing the Division's leadership and influence in public health in Idaho. To accomplish this goal, the DPH is committed to working closely with partners, both within the Idaho Department of Health and Welfare and across the state, to better understand the health issues of Idahoans, the underlying factors that impact health, and the resources and gaps that provide a wealth of untapped opportunity.

The population health assessment is the most comprehensive assessment of the health of Idahoans. With the completion of the five year assessment and ensuing annual review and update, the DPH maintains a current view of the health of Idahoans and the continued areas of progress and deficiencies. *Get Healthy Idaho: Measuring and Improving Population Health*, provides the road map.

Assessment Process Overview
Two frameworks provide structure and guidance to the assessment process: "The Community Health Assessment Toolkit," published by the Association for Community Health Improvement and the "Planning and Conducting Needs Assessments: A Practical Guide," by Wilkin and Altschuld.

For the first health assessment, completed in 2015, community level data in the format of local public health and hospital health needs assessments, available between June and October of 2014, were collected and analyzed (using primarily qualitative methods). Information from these assessments was compiled to align with the seven local Public Health District geographic areas. Additionally, the DPH identified other health assessments currently underway that complement the health needs assessments. These assessments included the Maternal and Child Health Five Year Needs Assessment and the Primary Care Needs Assessment. The national Public Health Accreditation Board (PHAB) standards also informed the data refining process. PHAB identifies what it considers core public health programs and, as data were assessed, only data that fell within the framework of PHAB were prioritized to move forward for consideration in the health improvement plan.

As part of the DPH's annual data assessment and review, health assessments were conducted in the fall of 2016, 2017, and 2018 among members of the Population Health Work Group (PHWG). The assessments were administered via an online survey tool and focused on questions from the 2014 population health needs assessments seeking data about health priorities at the local level including new concerns, gaps, assets, and resources. A Population Health Assessment Survey link was sent out to individual PHWG members and key partners with a request to forward the survey link to anyone else who might contribute to the health assessment. There were 18 completed surveys collected in 2016, 12 completed surveys in 2017, and 5 completed in 2018. Responses were integrated with the prior year's results to help identify public health priorities and strategies. The most recent information was shared with the PHWG in November, 2018.

The full results of the 2015 to 2018 assessments are included in tables at the end of this report beginning on page 91.

Summary of Findings
The following priority health issues were identified by the health assessment respondents as priority health issues, with the 10 highest priorities among all of the responses listed here (highest priority listed at the top with number of references from 2015 to 2018 combined):

- Obesity (23)
- Tobacco Use (23)
- Diabetes (22)
- Mental Health/Behavioral Health (22)
- Suicide (16)
- Access to Care/Uninsured (16)
- Substance Abuse (16)
- Physical Activity (15)
- Cardiovascular Health (15)
- Nutrition/Food Insecurity (12)

Among the top health priorities it is important to note that Suicide and Mental Health/Behavioral Health are often referred to as a single issue, and if combined, would top the list of health priorities by a significant margin. Although neither of the two health issues have been selected as priority health areas for Idaho's health improvement focus, it is important to note the support that is growing in this area. During the 2016 Idaho Legislative session, approval for the creation of a statewide Suicide Prevention Program was passed and the Idaho Suicide Prevention Program was staffed and operating beginning July 1, 2016. There continues to be legislative support for Crisis Centers across the state. The SHIP efforts also focused on integrating behavioral health with primary care statewide.

The master list of priority health issues identified in assessments conducted from 2015 through 2018 include: Access to Care/Uninsured, Alcohol, Asthma, Alzheimer's Disease, Behavioral Health, Cancer, Cardiovascular Diseases (Heart Disease and Stroke), Chronic Disease, Diabetes, Early Childhood Care, Exercise/Physical Inactivity, Food Insecurity, Immunization, Maternal/Infant/Child Health, Nutrition, Obesity and Overweight, Oral Health, Physical Activity, Prenatal Care, Senior Health, Sexually Transmitted Diseases, Substance Abuse, Suicide, Tobacco Use, Unintentional Injury, and Vaccine Preventable Diseases.

Managing Performance
The *Get Healthy Idaho* process includes quarterly reporting on progress toward identified measures and annual ongoing review of data. *Get Healthy Idaho* activities, assessment data, or both are consistent agenda items at meetings of the PHWG. At least annually one PHWG meeting is dedicated to: 1) reviewing the status of the current population health assessment and improvement plan, 2) discussing new and emerging health issues from both state and local perspectives, and 3) having an active and engaged dialogue among partners. The annual meeting is an opportunity for partners to provide input on what is working and what is not, to share their perspectives, and guide the creation of goals for the coming year. At this meeting, an update on the Idaho Leading Health Indicators and the identified priorities of *Get Healthy Idaho* are discussed. Partners are updated on work that has been achieved and work that is planned. Partners contribute to the assessment of new assets and resources and identify emerging issues that may be part of future improvement plans.

Assessment Content:
Data collected and reviewed for the population health assessment come from a number of sources. The following sections include detail on the data reviewed:

- **Demographics and Social Determinants of Health**
  These provide an overview of demographic and other issues that impact health.

- **Leading Causes of Death**
  The Leading Causes of Death section presents the leading causes in rank order for the state and then by sex and age. Data on years of potential life lost are also presented.

- **Idaho Leading Health Indicators**
  Idaho's Leading Health Indicators (LHIs), developed by the DPH, provide the framework for the core data of the assessment. The LHIs offer a consistent approach to assess the health of Idahoans and provide a way to determine if health status is changing and/or improving over time. The 2018 assessment includes an update of the LHIs with a redesign of the data pages providing more effective visualization of the data.

- **Health Professional Shortage Area Maps**
  These maps depict the most recent data on health professional shortage areas for primary care, mental health, and dental health. A population density map is also presented.

Demographics and Social Determinants of Health

General State Description

Idaho is a large western state with impressive mountain ranges, large areas of high desert and massive expanses of forested terrain. Idaho contains the second largest wilderness area in the lower 48 states, the Frank Church – River of No Return Wilderness, which covers almost 2.4 million acres.[1] Geography and distance impact both the demographic characteristics and social determinants of health within Idaho. Idaho is ranked 39th of the 50 United States for total population and 14th for geographic size.[2,3] The 2017 estimated population for Idaho was 1,716,943 and because of its large size and relatively small population, Idaho remains one of the most rural states in the nation.[2] With approximately 20.5, people per square mile Idaho ranks 44th of the 50 states in population density. The national average population density is 92.2 people per square mile, a four-fold greater density than Idaho.[3] Thirty-five of Idaho's 44 counties are rural with 19 of these considered frontier, having fewer than six people per square mile.[4]

The racial groups that comprised Idaho's population in 2017 were: (a) white, 93.3%; (b) black, 0.8%; (c) American Indian/ Alaska Native, 1.8%; and (d) Asian or Pacific Islander, 1.7%. It is estimated that 2.4% of Idahoans identify as being of two or more races. Persons of Hispanic or Latino origin comprised 12.3% of Idaho's total population.[5] Idaho is home to six federally recognized tribes: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes of the Fort Hall Reservation, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribes of the Duck Valley Reservation.[6] Idaho also has two refugee centers located in Ada County in southwest Idaho and Twin Falls County in south central Idaho.

Social Determinants and other Demographics

The conditions in which people are born, live, learn, work, and play have a substantial impact on health outcomes. These conditions, known as the social determinants of health, are important to consider when thinking about improving the health of a population. They vary at every stage of life and include factors such as age, personal behaviors, socioeconomic status, educational attainment, employment status, the physical environment, and access to care.[7] While these social determinant measures are not included within this report, many of the measures are available online at: http://gethealthy.dhw.idaho.gov.

According to the U.S. Census 2016 Current Population Survey, 14.4% of Idahoans were living below the poverty level and the median household income in Idaho is $49,174. Idaho's per capita income in 2016 was $24,280.[5] Idaho is an important agricultural state, producing nearly one-third of the potatoes grown in the United States. Wheat, sugar beets, and alfalfa hay are also major crops. Other industries contributing to Idaho's economy include information technology, mining, lumber, tourism and manufacturing.

The most recent national data (2016) indicate that the percentage of Idahoans over the age of 25 who have graduated from high school is higher than the national average (90.0% and 87.1%, respectively). However, college attendance rates are among the nation's lowest with 44% of Idaho's 2014 high school graduates enrolled in a two- or four-year college (National Center for Higher Education Management Systems, 2016). A quarter (26.2%) of Idahoans over the age of 25 hold a bachelor's degree or higher, compared with the national average of 30.3%.[8]

Public Health District Description

To facilitate the availability of public health services, contiguous counties in Idaho have been aggregated into seven public health districts to cover all 44 counties. These seven areas are defined by geographic barriers as well as transportation routes and population centers. Access to healthcare and other services have been identified as barriers to improving health outcomes for Idaho residents, however Idaho's seven health districts are primary outlets for public health services. Each district responds to local needs to provide services that may vary from district to district, ranging from community health nursing and home health nursing to environmental health, dental hygiene and nutrition. Many services are provided through contracts with DPH.

Health Professional Shortage

In 2018, the first college of osteopathic medicine began operating in Idaho for the purpose of training and developing physicians. The Idaho College of Osteopathic Medicine (ICOM) has been granted pre-accreditation status while it continues working towards establishing full accreditation status from the Commission on Osteopathic College Accreditation (COCA). In 2017, 100% of Idaho was a federally-designated mental health professional shortage area, 96% of Idaho was a federally-designated shortage area in primary care, and 97% of Idaho was designated a dental health professional shortage area.[9] Idaho had 73.1 primary care physicians per 100,000 population in 2016.[10] In 2018, the Idaho Hospital Association membership directory reported 48 hospitals (including facilities in Oregon, Washington, and Wyoming). Twenty-seven of these hospitals are critical access hospitals, owning 55 clinics. These clinics include primary care and specialty services and may be co-located with the hospital as well as remote clinics. [11]

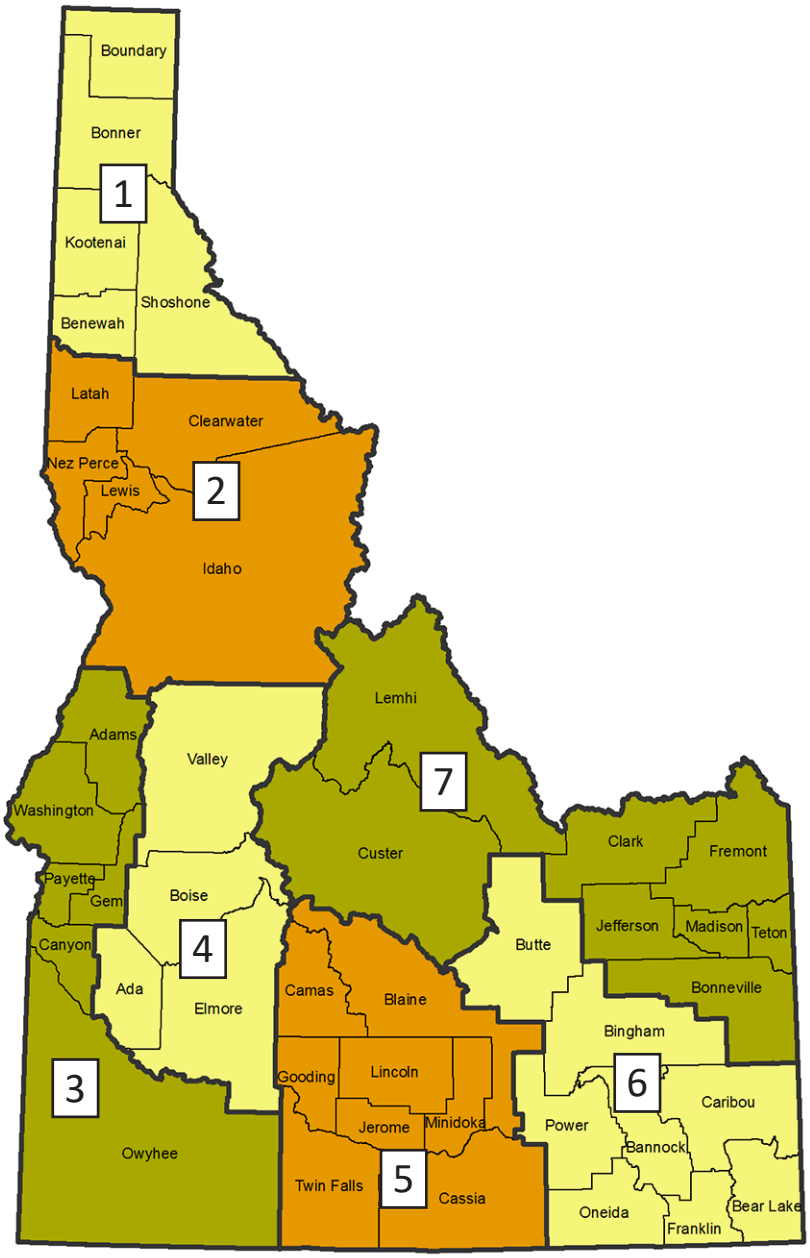
Idaho Medicaid and Access

Idaho Medicaid enrollment averaged 300,838 participants per month in State Fiscal Year (SFY) 2017 (July-June), an increase of 4.6% from SFY2016. The projected growth rate is forecast to decline as compared to the Medicaid growth experienced during the peak of the recession and will more closely approach our historical average growth. The enrollment increase in SFY2014 can be attributed primarily to the Affordable Care Act (ACA) requiring people to have insurance coverage. Once past the ACA enrollment period, Idaho expects to return to a 2% to 3% enrollment growth rate; however, recent changes in federal mandates will likely further impact insurance coverage enrollment.[12]

In November of 2014, Your Health Idaho began operating as Idaho's fully state-based health insurance marketplace. For the 2017 coverage year, Idaho was third in the nation for the number of residents (per capita) who selected health insurance plans, and 106,000 Idahoans enrolled in marketplace plans in 2017.[13]

In November 2018, Idaho voters passed Proposition 2 – Medicaid Expansion by over a 60% majority. The 2019 legislature will work on the implementation plan and appropriation of the state's share of funding.

Idaho Public Health District Map



Panhandle Health District	Pubic Health - Idaho North Central District	Southwest District Health	Central District Health Department	South Central Public Health District	Southeastern Idaho Public Health	Eastern Idaho Public Health
PHD 1	PHD 2	PHD 3	PHD 4	PHD 5	PHD 6	PHD 7
Benewah Bonner Boundary Kootenai Shoshone	Clearwater Idaho Latah Lewis Nez Perce	Adams Canyon Gem Owyhee Payette Washington	Ada Boise Elmore Valley	Blaine Camas Cassia Gooding Jerome Lincoln Minidoka Twin Falls	Bannock Bear Lake Bingham Butte Caribou Franklin Oneida Power	Bonneville Clark Custer Fremont Jefferson Lemhi Madison Teton

Demographics and Social Determinants of Health
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Leading Causes of Death to Idaho Residents
Cause-Specific Crude and Age-Adjusted Rates, 2017 Idaho and 2016 U.S.

Cause of Death (Ranked for Idaho)	Deaths		Death Rates[1]			
			Crude		Age-Adjusted[2]	
	Number	Percent	Idaho[3]	U.S.[4]	Idaho[3]	U.S.[4]
ALL CAUSES	14,007	100.0%	815.8	849.3	741.6	728.8
1. Diseases of heart	3,085	22.0%	179.7	196.6	162.5	165.5
2. Malignant neoplasms (cancer)	3,015	21.5%	175.6	185.1	153.0	155.8
3. Chronic lower respiratory diseases	925	6.6%	53.9	47.8	47.2	40.6
4. Accidents (unintentional injury)	878	6.3%	51.1	49.9	49.9	47.4
5. Cerebrovascular diseases	722	5.2%	42.1	44.0	38.3	37.3
6. Alzheimer's disease	673	4.8%	39.2	35.9	36.7	30.3
7. Diabetes mellitus	393	2.8%	22.9	24.8	20.3	21.0
tie Intentional self-harm (suicide)	393	2.8%	22.9	13.9	23.2	13.5
9. Influenza and pneumonia	257	1.8%	15.0	15.9	13.8	13.5
10. Parkinson's disease	205	1.5%	11.9	9.2	11.1	8.0
11. Chronic liver disease and cirrhosis	197	1.4%	11.5	12.5	10.2	10.7
12. Nephritis, nephrotic syndrome, nephrosis	172	1.2%	10.0	15.5	9.1	13.1
13. Septicemia	115	0.8%	6.7	12.6	6.1	10.7
14. Pneumonitis due to solids and liquids	102	0.7%	5.9	6.1	5.4	5.2
15. Essential hypertension & hypertensive renal disease	95	0.7%	5.5	10.3	5.0	8.6
All other causes	2,780	19.8%	NA	NA	NA	NA

1. Rates are per 100,000 population. NA = not applicable. Rates are not applicable for all other causes.
2. Age-adjusted rates are artificial measures used to compare populations that have different age compositions (so long as the rate was calculated using the same standard population). Idaho and U.S. age-adjusted rates were calculated using the 2000 U.S. population estimate as the standard population.
3. Idaho rates are based on the July 1, 2017 population estimates.
4. Source U.S. crude and age-adjusted rates: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017.
Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

Leading Causes of Death to Idahoans by Sex
Cause-Specific Crude and Age-Adjusted Rates, 2017 Idaho and 2016 U.S.

Males						
Cause of Death (Ranked for Idaho)	Deaths		Crude		Age-Adjusted[2]	
	Number	Percent	Idaho[3]	U.S.[4]	Idaho[3]	U.S.[4]
ALL CAUSES	7,364	100.0%	855.8	880.2	852.0	861.0
1. Diseases of heart	1,737	23.6%	201.9	213.3	203.3	209.1
2. Malignant neoplasms (cancer)	1,638	22.2%	190.4	197.7	180.0	185.4
3. Accidents (unintentional injury)	544	7.4%	63.2	65.3	64.6	65.0
4. Chronic lower respiratory diseases	448	6.1%	52.1	45.9	49.9	45.1
5. Intentional self-harm (suicide)	321	4.4%	37.3	21.8	38.0	21.4
6. Cerebrovascular diseases	311	4.2%	36.1	37.3	37.0	37.5
7. Diabetes mellitus	223	3.0%	25.9	27.5	24.8	26.0
8. Alzheimer's disease	194	2.6%	22.5	22.2	25.1	24.3
9. Parkinson's disease	135	1.8%	15.7	11.2	16.5	12.0
10. Chronic liver disease and cirrhosis	130	1.8%	15.1	16.2	13.5	14.3
11. Influenza and pneumonia	117	1.6%	13.6	15.7	14.0	15.9
12. Nephritis, nephrotic syndrome, nephrosis	100	1.4%	11.6	16.0	12.1	15.9
13. Pneumonitis due to solids and liquids	62	0.8%	7.2	12.4	7.3	12.0
14. Septicemia	54	0.7%	6.3	6.8	7.0	7.0
15. In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	43	0.6%	5.0	5.3	5.1	5.3
All other causes	1,307	17.7%	NA	NA	NA	NA

Females						
Cause of Death (Ranked for Idaho)	Deaths		Crude		Age-Adjusted[2]	
	Number	Percent	Idaho[3]	U.S.[4]	Idaho[3]	U.S.[4]
ALL CAUSES	6,643	100.0%	775.6	819.3	642.2	617.5
1. Malignant neoplasms (cancer)	1,377	20.7%	160.8	172.8	131.4	134.0
2. Diseases of heart	1,348	20.3%	157.4	180.4	127.7	130.4
3. Alzheimer's disease	479	7.2%	55.9	49.2	45.1	33.9
4. Chronic lower respiratory diseases	477	7.2%	55.7	49.7	45.3	37.4
5. Cerebrovascular diseases	411	6.2%	48.0	50.5	39.0	36.5
6. Accidents (unintentional injury)	334	5.0%	39.0	35.1	35.7	30.8
7. Diabetes mellitus	170	2.6%	19.8	22.1	16.2	16.9
8. Influenza and pneumonia	140	2.1%	16.3	16.2	13.7	11.8
9. Intentional self-harm (suicide)	72	1.1%	8.4	6.2	8.7	6.0
tie Nephritis, nephrotic syndrome, nephrosis	72	1.1%	8.4	15.0	6.8	11.2
11. Parkinson's disease	70	1.1%	8.2	7.2	6.8	5.3
12. Chronic liver disease and cirrhosis	67	1.0%	7.8	9.0	7.2	7.5
13. Essential hypertension & hypertensive renal disease	54	0.8%	6.3	11.4	5.0	8.2
14. Septicemia	53	0.8%	6.2	12.8	5.3	9.7
15. Pneumonitis due to solids and liquids	48	0.7%	5.6	5.4	4.3	3.9
All other causes	1,471	22.1%	NA	NA	NA	NA

1. Rates are per 100,000 population. NA = not applicable. Rates are not applicable for all other causes.
2. Age-adjusted rates are artificial measures used to compare populations that have different age compositions (so long as the rate was calculated using the same standard population). Idaho and U.S. age-adjusted rates were calculated using the 2000 U.S. population estimate as the standard population.
3. Idaho rates are based on the July 1, 2017 population estimates.
4. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2016 on CDC WONDER Online Database, released December, 2017.
Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

IDAHO RESIDENT MORTALITY
Ten Leading Causes of Mortality[1] by Age Group and Number of Deaths
2017

RANK	AGE GROUP											ALL AGES
	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
1	Congenital malformations 28	Accidents (unintentional injury) 11	Accidents (unintentional injury) 21	Accidents (unintentional injury) 70	Accidents (unintentional injury) 105	Accidents (unintentional injury) 92	Malignant neoplasms (cancer) 153	Malignant neoplasms (cancer) 542	Malignant neoplasms (cancer) 847	Malignant neoplasms (cancer) 835	Diseases of heart 1,274	Diseases of heart 3,085
2	Sudden infant death syndrome 10	Congenital malformations, deformations 6	(Tie) Assault (homicide); Congenital malformations; Intentional self-harm; Malignant neoplasms	Intentional self-harm (suicide) 56	Intentional self-harm (suicide) 70	Intentional self-harm (suicide) 68	Accidents (unintentional injury) 112	Diseases of heart 315	Diseases of heart 544	Diseases of heart 782	Malignant neoplasms (cancer) 558	Malignant neoplasms (cancer) 3,015
3	(Tie) Short gestation & low birth weight; Maternal complications of pregnancy 8			(Tie) Assault (homicide); Malignant neoplasms (cancer) 6	Diseases of heart 17	Malignant neoplasms (cancer) 53	Diseases of heart 110	Accidents (unintentional injury) 114	Chronic lower respiratory diseases 270	Chronic lower respiratory diseases 317	Alzheimer's disease 418	Chronic lower respiratory diseases 925
4					Malignant neoplasms (cancer) 15	Diseases of heart 35	Intentional self-harm (suicide) 66	Chronic lower respiratory diseases 101	Cerebrovas-cular diseases 120	Cerebrovas-cular diseases 213	Cerebrovas-cular diseases 319	Accidents (unintentional injury) 878
5	Complications of placenta 6		3		Assault (homicide) 13	Chronic liver disease and cirrhosis 19	Chronic liver disease and cirrhosis 35	Intentional self-harm (suicide) 67	Diabetes mellitus 108	Alzheimer's disease 192	Chronic lower respiratory diseases 215	Cerebrovas-cular diseases 722
6	(Tie) Accidents (unintentional injury); Respiratory distress of the newborn 4				Congenital malformations, deformations 5	Diabetes mellitus 12	Diabetes mellitus 27	Chronic liver disease and cirrhosis 65	Accidents (unintentional injury) 100	Diabetes mellitus 102	Accidents (unintentional injury) 157	Alzheimer's disease 673
7					Pregnancy, childbirth, and the 3	Assault (homicide) 9	Cerebrovas-cular diseases 18	Diabetes mellitus 62	Alzheimer's disease 53	Accidents (unintentional injury) 92	Influenza and pneumonia 116	(Tie) Diabetes mellitus; Intentional self-harm (suicide) 393
8	(Tie) Intrauterine hypoxia and birth asphyxia; Complications of labor and delivery 3					(Tie) Chronic lower respiratory diseases; Influenza and pneumonia 4	Chronic lower respiratory diseases 15	Cerebrovas-cular diseases 48	Chronic liver disease and cirrhosis 46	Parkinson's disease 90	Diabetes mellitus 80	
9							Influenza and pneumonia 13	(Tie) Influenza and pneumonia; Septicemia	Influenza and pneumonia 37	Influenza and pneumonia 68	Parkinson's disease 77	Influenza and pneumonia 257
10						Septicemia 3	Septicemia 12	18	Parkinson's disease 33	Nephritis 50	Nephritis 67	Parkinson's disease 205
Residual[2]	27	8	10	23	47	66	129	321	522	820	1,154	3,461
Total	101	25	43	161	275	365	690	1,671	2,680	3,561	4,435	14,007

Nephritis is a shorted ICD-10 title for 'Nephritis, nephrotic syndrome, nephrosis'; Complication of placenta is short for "Complications of placenta, cord and membranes'"; Congenital malformations is short for "Congenital malformations, deformations, and chromosomal abnormalities.'

[1]Data are shown for causes with 3 or more deaths for given age group. [2]Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2017.

IDAHO MALE RESIDENT MORTALITY
Ten Leading Causes of Mortality[1] by Age Group and Number of Deaths
2017

RANK	AGE GROUP											ALL AGES
	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
1	Congenital malformations 14	Accidents (unintentional injury) 6	Accidents (unintentional injury) 14	Intentional self-harm (suicide) 51	Accidents (unintentional injury) 74	Accidents (unintentional injury) 65	Diseases of heart 72	Malignant neoplasms (cancer) 292	Malignant neoplasms (cancer) 467	Malignant neoplasms (cancer) 477	Diseases of heart 570	Diseases of heart 1,737
2	Maternal complications of pregnancy 6			Accidents (unintentional injury) 49	Intentional self-harm (suicide) 56	Intentional self-harm (suicide) 55	Accidents (unintentional injury) 71	Diseases of heart 225	Diseases of heart 373	Diseases of heart 460	Malignant neoplasms (cancer) 291	Malignant neoplasms (cancer) 1,638
3	Short gestation and low birth 5			Malignant neoplasms (cancer) 5	Diseases of heart 12	Malignant neoplasms (cancer) 27	Malignant neoplasms (cancer) 70	Accidents (unintentional injury) 76	Chronic lower respiratory diseases 147	Chronic lower respiratory diseases 147	(Tie) Alzheimer's disease; Cerebrovas-cular disease 109	Accidents (unintentional injury) 544
4	Sudden infant death syndrome 4			Assault (homicide) 4	Assault (homicide) 10	Diseases of heart 22	Intentional self-harm (suicide) 47	Intentional self-harm (suicide) 57	(Tie) Cerebrovas-cular diseases; Diabetes mellitus 64	Cerebrovas-cular diseases 96		Chronic lower respiratory diseases 448
5				Diseases of heart 3	Malignant neoplasms (cancer) 9	Diabetes mellitus 10	Chronic liver disease and cirrhosis 22	Chronic liver disease and cirrhosis 49		Alzheimer's disease 63	Chronic lower respiratory diseases 95	Intentional self-harm (suicide) 321
6					Congenital malformations 4	Chronic liver disease and cirrhosis 7	Diabetes mellitus 18	Chronic lower respiratory diseases 45	Accidents (unintentional injury) 62	Parkinson's disease 62	Accidents (unintentional injury) 67	Cerebrovas-cular diseases 311
7						Assault (homicide) 5	Cerebrovas-cular diseases 11	Diabetes mellitus 38	Chronic liver disease and cirrhosis 30	Accidents (unintentional injury) 58	(Tie) Influenza and pneumonia; Parkinson's disease 45	Diabetes mellitus 223
8							Chronic lower respiratory diseases 10	Cerebrovas-cular diseases 29	Parkinson's disease 24	Diabetes mellitus 55		Alzheimer's disease 194
9							Septicemia 7	Influenza and pneumonia 13	Intentional self-harm (suicide) 23	Influenza and pneumonia 31	(Tie) Diabetes mellitus; Nephritis 38	Parkinson's disease 135
10							Influenza and pneumonia 5	(Tie) Nephritis; Septicemia 11	Influenza and pneumonia 22	Nephritis 27		Chronic liver disease and cirrhosis 130
Residual[2]	20	6	12	9	28	41	60	173	293	436	431	1,683
Total	49	12	26	121	193	232	393	1,019	1,569	1,912	1,838	7,364

Nephritis is a shorted ICD-10 title for 'Nephritis, nephrotic syndrome, nephrosis'; Congenital malformations is short for "Congenital malformations, deformations, and chromosomal abnormalities.'

[1]Data are shown for causes with 3 or more deaths for given age group. [2]Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2018.

IDAHO FEMALE RESIDENT MORTALITY
Ten Leading Causes of Mortality[1] by Age Group and Number of Deaths
2017

RANK	AGE GROUP											ALL AGES
	<1	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
1	Congenital malformations 14	(Tie) Accidents (unintentional injury); Congenital malformations 5	Accidents (unintentional injury) 7	Accidents (unintentional injury) 21	Accidents (unintentional injury) 31	Accidents (unintentional injury) 27	Malignant neoplasms (cancer) 83	Malignant neoplasms (cancer) 250	Malignant neoplasms (cancer) 380	Malignant neoplasms (cancer) 358	Diseases of heart 704	Malignant neoplasms (cancer) 1,377
2	Sudden infant death syndrome 6		Malignant neoplasms 3	Intentional self-harm (suicide) 5	Intentional self-harm (suicide) 14	Malignant neoplasms (cancer) 26	Accidents (unintentional injury) 41	Diseases of heart 90	Diseases of heart 171	Diseases of heart 322	Alzheimer's disease 309	Diseases of heart 1,348
3	Complications of placenta, cord & 4				Malignant neoplasms (cancer) 6	(Tie) Diseases of heart; Intentional self-harm (suicide) 13	Diseases of heart 38	Chronic lower respiratory diseases 56	Chronic lower respiratory diseases 123	Chronic lower respiratory diseases 170	Malignant neoplasms (cancer) 267	Alzheimer's disease 479
4	Short gestation and low birth 3				Diseases of heart 5		Intentional self-harm (suicide) 19	Accidents (unintentional injury) 38	Cerebrovas-cular diseases 56	Alzheimer's disease 129	Cerebrovas-cular diseases 210	Chronic lower respiratory diseases 477
5					(Tie) Assault (homicide); Pregnancy, childbirth, and the puerperium 3	Chronic liver disease and cirrhosis 12	Chronic liver disease and cirrhosis 13	Diabetes mellitus 24	Diabetes mellitus 44	Cerebrovas-cular diseases 117	Chronic lower respiratory diseases 120	Cerebrovas-cular diseases 411
6						Assault (homicide) 4	Diabetes mellitus 9	Cerebrovas-cular diseases 19	Accidents (unintentional injury) 38	Diabetes mellitus 47	Accidents (unintentional injury) 90	Accidents (unintentional injury) 334
7						(Tie) Chronic lower respiratory diseases; Influenza and pneumonia 3	Influenza and pneumonia 8	Chronic liver disease and cirrhosis 16	Alzheimer's disease 34	Influenza and pneumonia 37	Influenza and pneumonia 71	Diabetes mellitus 170
8							Cerebrovas-cular diseases 7	Intentional self-harm (suicide) 10	Chronic liver disease and cirrhosis 16	Accidents (unintentional injury) 34	Diabetes mellitus 42	Influenza and pneumonia 140
9							(Tie) Chronic lower respiratory diseases; Septicemia 5	Septicemia 7	(Tie) Influenza and pneumonia; Nephritis 15	Parkinson's disease 28	Essential hypertension 36	(Tie) Nephritis; Intentional self-harm (suicide) 72
10								Alzheimer's disease 6		Nephritis 23	Parkinson's disease 32	
Residual[2]	25	3	7	14	20	32	69	136	219	384	716	1,763
Total	52	13	17	40	82	133	297	652	1,111	1,649	2,597	6,643

Nephritis is a shorted ICD-10 title for 'Nephritis, nephrotic syndrome, nephrosis'; Congenital malformations is short for "Congenital malformations, deformations, and chromosomal abnormalities'; Essential hypertension is short for 'Essential hypertension and hypertensive renal disease.'

[1]Data are shown for causes with 3 or more deaths for given age group. [2]Total number of deaths for all other leading causes not listed and all other causes not ranked for leading cause of death.

Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2018.

Years of Potential Life Lost Before Age 75
Ten Leading Causes of Death Based on Premature Mortality[1]
Total Population and by Sex, 2017

Cause of Death (Ranked)	Persons Aged Less than 75 Years		Years of Potential Life Lost (YPLL) Before Age 75		
	Number of Deaths	Percent of Deaths	Average Number of YPLL per Death	Total Number of YPLL	YPLL Rate[2]
Total	6,011	100.0%	16.6	99,488	6,168
1. Accidents (unintentional injury)	629	10.5%	30.3	19,069	1,182
2. Malignant neoplasms (cancer)	1,622	27.0%	11.6	18,749	1,162
3. Diseases of heart	1,029	17.1%	11.9	12,229	758
4. Intentional self-harm (suicide)	361	6.0%	32.3	11,659	723
5. Chronic lower respiratory diseases	393	6.5%	8.3	3,260	202
6. Congenital malformations, deformations and chromosomal abnormalities	60	1.0%	54.2	3,254	202
7. Certain conditions originating in perinatal period	42	0.7%	74.5	3,129	194
8. Chronic liver disease and cirrhosis	166	2.8%	16.8	2,786	173
9. Diabetes mellitus	211	3.5%	12.6	2,667	165
10. Cerebrovascular diseases	190	3.2%	10.0	1,904	118
All other causes	1,308	21.8%	N/A	N/A	N/A
Total Males	3,614	100.0%	17.0	61,279	7,530
1. Accidents (unintentional injury)	419	11.6%	30.8	12,902	1,585
2. Malignant neoplasms (cancer)	870	24.1%	11.1	9,648	1,186
3. Intentional self-harm (suicide)	291	8.1%	32.9	9,575	1,177
4. Diseases of heart	707	19.6%	11.7	8,262	1,015
5. Certain conditions originating in perinatal period	24	0.7%	74.5	1,788	220
6. Diabetes mellitus	130	3.6%	13.0	1,695	208
7. Chronic lower respiratory diseases	206	5.7%	8.2	1,692	208
8. Chronic liver disease and cirrhosis	108	3.0%	15.5	1,677	206
9. Congenital malformations, deformations and chromosomal abnormalities	35	1.0%	47.8	1,672	205
10. Cerebrovascular diseases	106	2.9%	10.5	1,111	137
All other causes	718	19.9%	N/A	N/A	N/A
Total Females	2,397	100.0%	15.9	38,209	4,782
1. Malignant neoplasms (cancer)	752	31.4%	12.1	9,101	1,139
2. Accidents (unintentional injury)	210	8.8%	29.4	6,167	772
3. Diseases of heart	322	13.4%	12.3	3,967	496
4. Intentional self-harm (suicide)	70	2.9%	29.8	2,084	261
5. Congenital malformations, deformations and chromosomal abnormalities	25	1.0%	63.3	1,583	198
6. Chronic lower respiratory diseases	187	7.8%	8.4	1,568	196
7. Certain conditions originating in perinatal period	18	0.8%	74.5	1,341	168
8. Chronic liver disease and cirrhosis	58	2.4%	19.1	1,109	139
9. Diabetes mellitus	81	3.4%	12.0	972	122
10. Assault (homicide)	20	0.8%	41.2	823	103
All other causes	654	27.3%	N/A	N/A	N/A

1. Ranking based on total number of years of potential life lost (YPLL).
2. YPLL rate: Total number of years of potential life lost per 100,000 population aged less than 75 years.
N/A: not applicable. YPLL not applicable for "All other causes."
Source: Bureau of Vital Records and Health Statistics, Division of Public Health, Idaho Department of Health and Welfare, 2018.

Idaho Leading Health Indicators

Topic Area	Leading Health Indicator
Overweight/Obesity	Percentage of adolescents overweight/obese[1] Percentage of Idaho adults who are overweight/obese[2]
Tobacco Use	Percentage of adolescents who currently smoke[1] Percentage of Idaho adults who are current smokers[2] Percentage of Idaho adults who use smokeless tobacco[2]
Immunization	Percentage of 19-35 month olds who received 4+doses of DTaP[3] Percentage of adolescents aged 13 to 15 years reporting having been vaccinated with 3+ doses of the HPV vaccine[3] Annual incidence of Pertussis (Whooping Cough)[4]
Infectious Disease	Annual incidence rate of enteric diseases reportable to public health[4] Annual incidence of STDs (chlamydia, gonorrhea, syphilis - does not include HIV)[4]
Perinatal Care	Percentage of Idaho mothers who received adequate prenatal care[5] Percentage of Idaho resident live births with low birth weight[5] Percentage of Idaho resident live births with pre-term delivery[5]
Injury/Suicide	Percentage of adolescents who have attempted suicide[1] Suicide death rates[6] Injury fatalities (ages 1-44)[6]
Chronic Disease	Coronary heart disease prevalence[2] Coronary heart disease death rates[6] Stroke prevalence[2] Stroke death rates[6] Diabetes prevalence[2]
Health Status/Behaviors	Percentage of Idaho adults who consume 5 or more servings of fruits and vegetables a day[2] Percentage of Idaho adults aged 50-75 years of age who receive colorectal cancer screening based on the most recent guidelines[2] Percentage of Idaho women aged 50-74 who receive a breast cancer screening based on the most recent guidelines[2] Percentage of Idaho adults with no leisure time physical activity[2] Percentage of Idaho adults who have not visited the dentist in the past 12 months[2]
Access/Systems	Percentage of Idaho adults without healthcare coverage[2] Percentage of Idaho adults without a usual healthcare provider[2] Number of active primary care physicians per 100,000[7]
Reproductive Health	Adolescent pregnancy rates (ages 15-17)[5] Percentage of adolescents that had sexual intercourse for the first time at 15 years or younger[1]

Data Sources/Notes:

1. Idaho Youth Risk Behavior Survey (YRBS), Idaho State Department of Education (SDE).
2. Idaho Behavioral Risk Factor Surveillance System (BRFSS) Survey, Bureau of Vital Records and Health Statistics (BVRHS), Idaho Department of Health and Welfare (IDHW).
3. National Immunization Survey (NIS), National Center for Immunization and Respiratory Diseases (NCIRD), Centers for Disease Control and Prevention (CDC).
4. Idaho Reportable Diseases, Bureau of Communicable Disease Prevention (BCDP), IDHW.
5. Birth records, BVRHS, IDHW.
6. Mortality (Death) records, BVRHS, IDHW.
7. 2017 State Physician Workforce Data Book, Association of American Medical Colleges.

*In cases where leading health indicator point estimates do not differ in a statistically significant manner there may be programmatically significant differences which have been highlighted. Unless specified, differences in estimates should not be considered statistically significant.
**For indicator definitions see the associated Leading Health Indicator in the following pages (35-68).

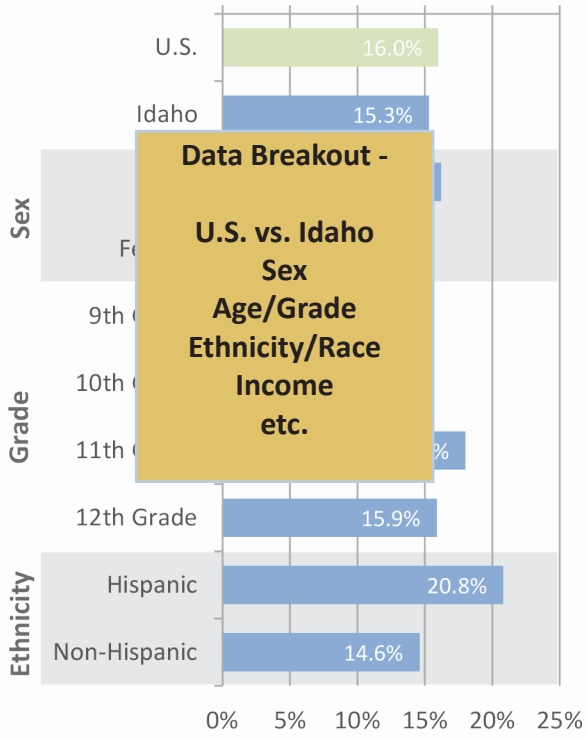
Understanding the Data Pages

Topic Area: Overweight/Obesity

Indicator: Percentage of adolescents (grades 9-12) who are overweight, 2015

10 Topic Areas
31 Indicators

The percentage of adolescents who are overweight in Idaho does not differ significantly from the U.S. Minor differences exist among some of the demographic groups listed below.[1]



Data Breakout -

U.S. vs. Idaho
Sex
Age/Grade
Ethnicity/Race
Income
etc.

Overweight: students who were at or above the 85th percentile but below the 95th percentile for body mass index (BMI), based on sex- and age-specific reference data from the 2000 CDC growth charts.

Indicator defined

How Many Adolescents?

13,000

15% of

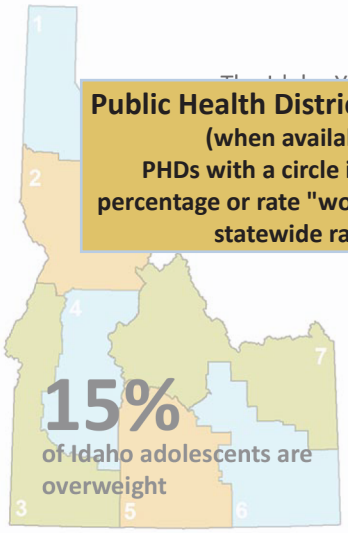
How many and who is at risk according to chart on the left

Who Are

Hispanic Students

21% vs. 15% of non-Hispanic students

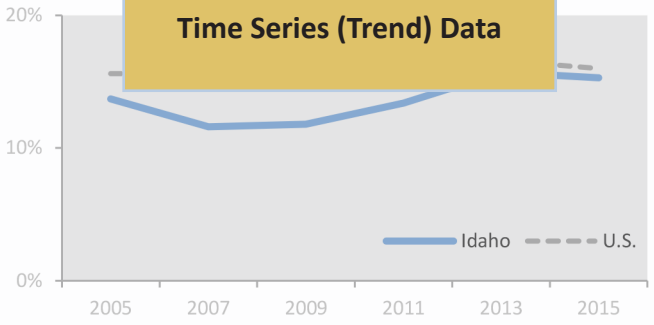
Where Are They?



Public Health District Estimates
(when available)
PHDs with a circle indicate a percentage or rate "worse" than the statewide rate.

2005-2015

The percentage of adolescents in Idaho who are overweight has increased slightly since 2005. Idaho's overweight prevalence has been lower than the U.S. rate over the past 10 years, however since 2013 the rates have co



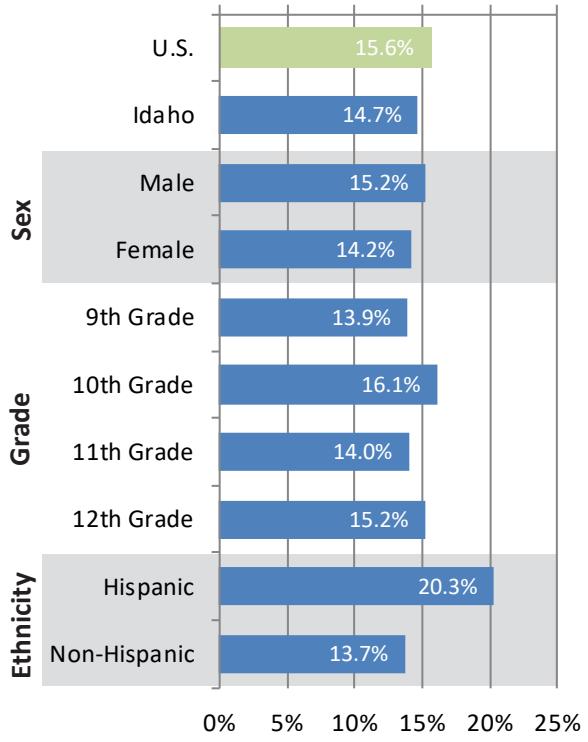
Time Series (Trend) Data

NOTE: In most cases, the ability to determine if differences between groups or years are statistically significant is not available. Where statistical significance is known it will be noted. In some cases "significance" is used to denote a difference that seem programmatically significant, but may not be statistically significant.

Data Source / Notes

1. Centers for Disease Control and Prevention (CDC). 1991-2015 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed July, 2016.

The percentage of adolescents who are overweight in **Idaho** does not differ significantly from the **U.S.** Minor differences exist among some of the demographic groups listed below.[1,2]



Overweight: students who were at or above the 85th percentile but below the 95th percentile for body mass index (BMI), based on sex- and age-specific reference data from the 2000 CDC growth charts.

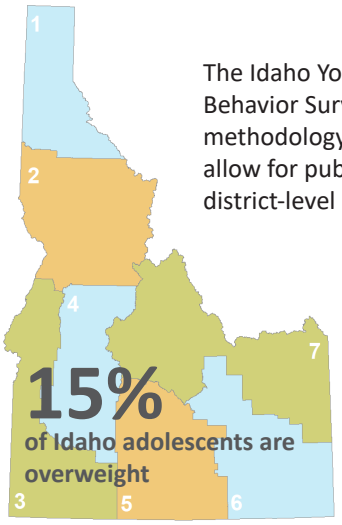
How Many Adolescents?

13,350
15% of Idaho adolescents (grades 9-12) are overweight

Who Are They?

Hispanic Students
20% vs. 14% of non-Hispanic students

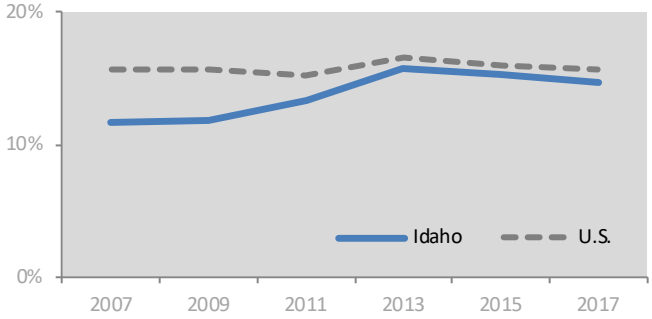
Where Are They?



The Idaho Youth Risk Behavior Survey (YRBS) methodology does not allow for public health district-level estimates

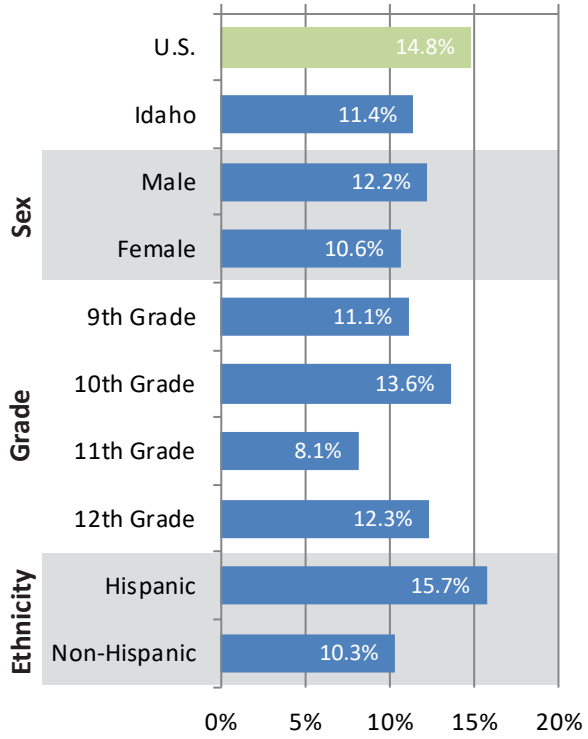
2007-2017

The percentage of adolescents in Idaho who are overweight decreased slightly from 2013 to 2017, however since 2007 the rate has increased significantly. Idaho's overweight prevalence has been lower than the **U.S.** rate over the past 10 years, however since 2013 the rates have converged.[1,2]



1. Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.
2. Centers for Disease Control and Prevention (CDC). 1991-2017 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed December, 2018.

The percentage of adolescents who are obese in **Idaho** does not differ significantly from the **U.S.** rate.[1,2] There are no statistically significant differences among sex, grade, or Hispanic ethnicity.



Obese: students who were at or above the 95th percentile for BMI, based on sex- and age-specific reference data from the 2000 CDC growth charts.

How Many Adolescents?

9,800

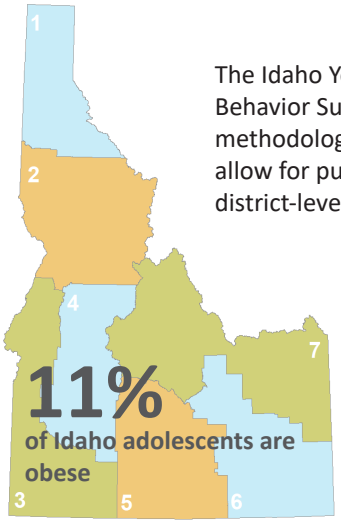
11% of Idaho adolescents (grades 9-12) are obese based on their BMI

Who Are They?

Hispanic Students

16% vs. 10% of non-Hispanic students are obese

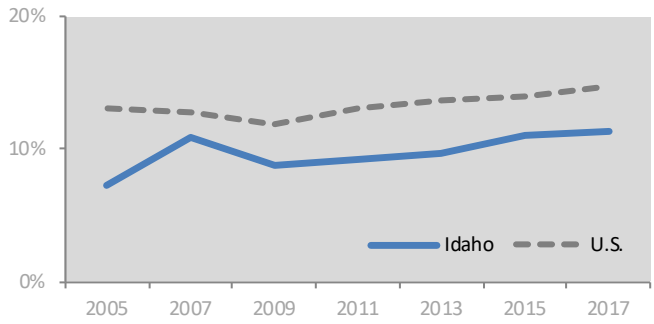
Where Are They?



The Idaho Youth Risk Behavior Survey (YRBS) methodology does not allow for public health district-level estimates

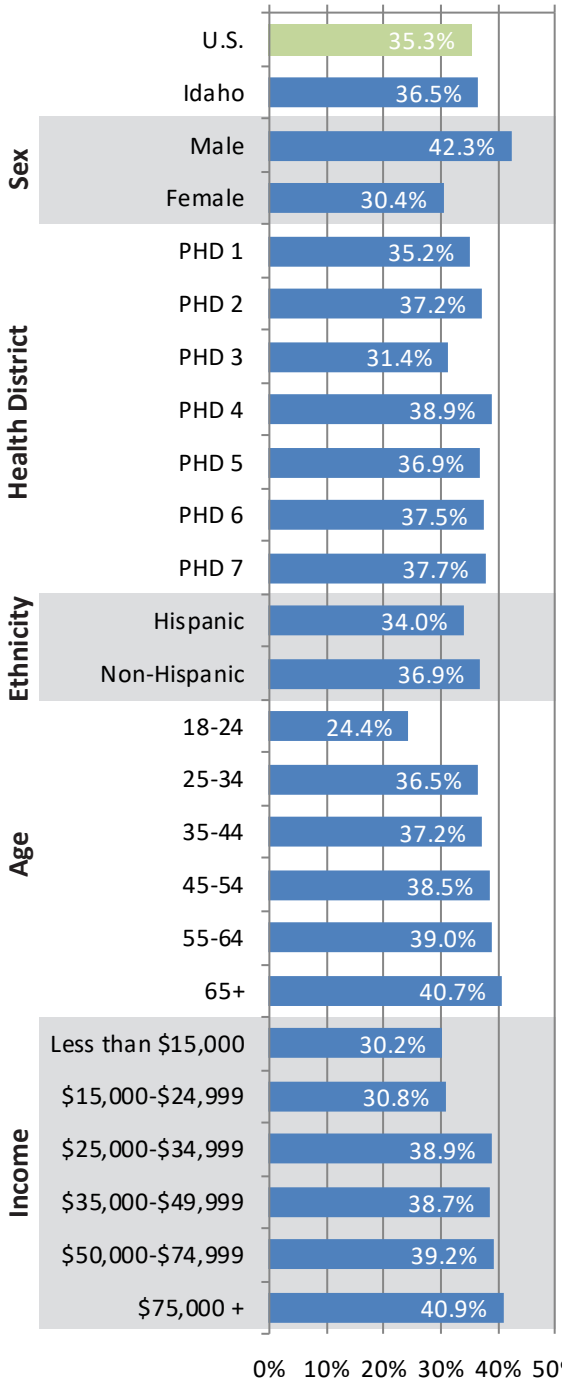
2007-2017

The percentage of obese adolescents in Idaho has increased significantly since 2011. Idaho's obesity prevalence has been consistently lower than the **U.S.** rate over the past 10 years.[1,2]



1. Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.
2. Centers for Disease Control and Prevention (CDC). 1991-2017 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed December, 2018.

The percentage of overweight (but not obese) adults in **Idaho** is slightly higher than the **U.S.** median. Some significant differences exist among demographic groups.[1]



Overweight is defined as a self-reported height and weight resulting in a calculated BMI greater than or equal to 25.0 but less than 30.0.

How Many Adults?

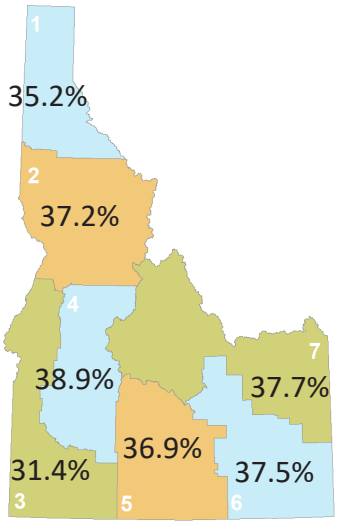
441,000
37% of Idaho adults are overweight

Who Are They?

Males
42% vs. 30% of females are overweight

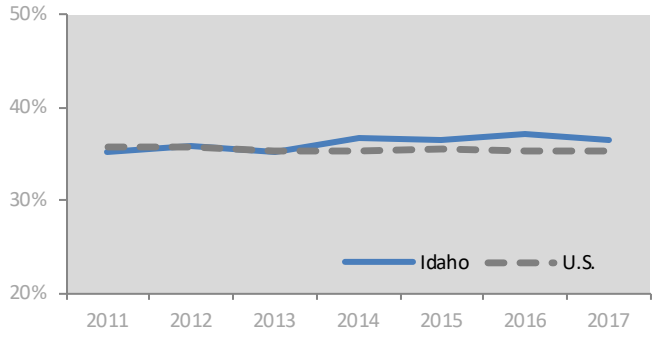
Income
Adults in higher income groups have higher rates of obesity

Where Are They?



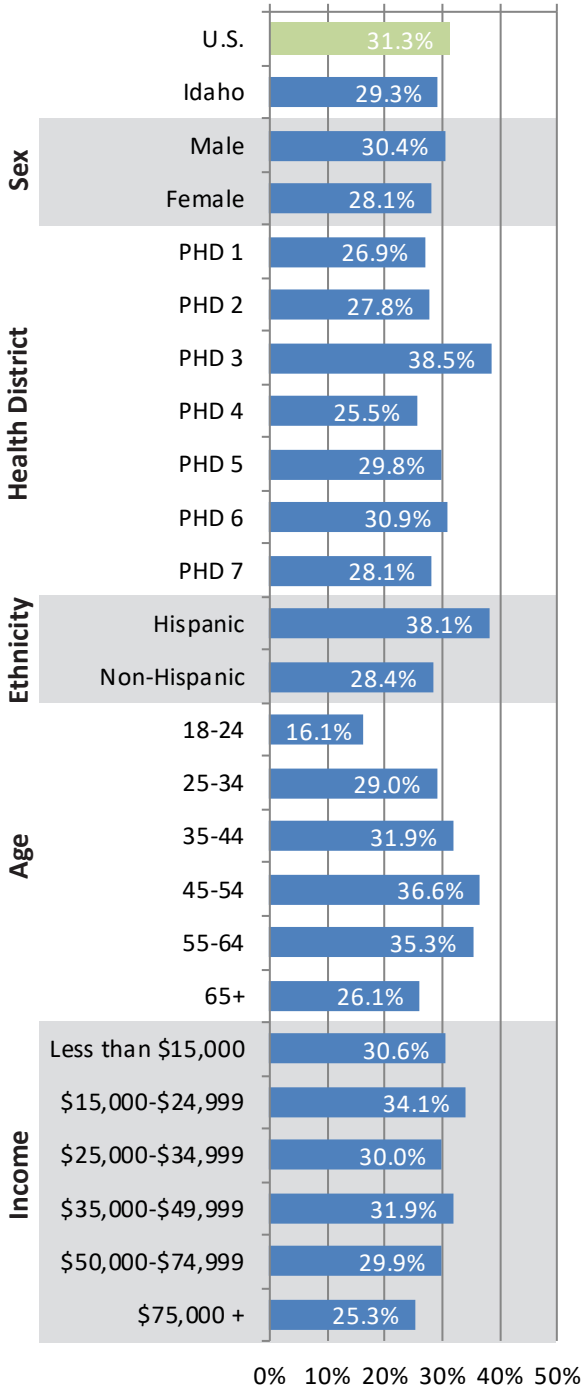
2011-2017

The percentage of overweight (but not obese) adults in Idaho remained relatively unchanged from 2011 to 2017. Idaho's overweight (but not obese) is similar to the **U.S.** median.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The percentage of obese adults in **Idaho** is slightly lower than the **U.S.** median. Some significant differences exist among demographic groups.[1]



Obese is defined as a self-reported height and weight resulting in a calculated BMI equal to or greater than 30.0.

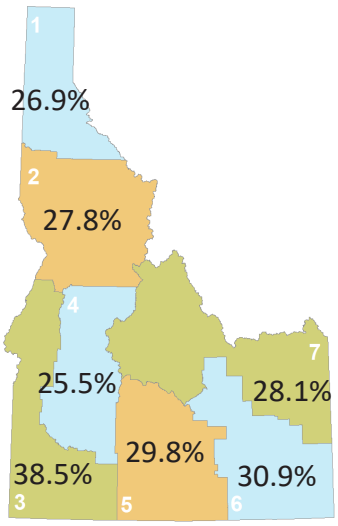
How Many Adults?

354,000
29% of Idaho adults are obese

Who Are They?

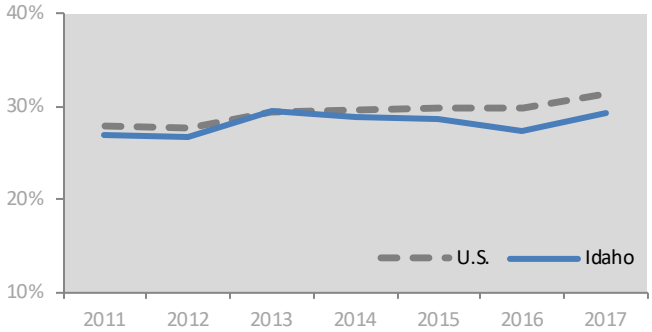
Middle-Aged Adults
37% of adults aged 45-54 are obese

Where Are They?



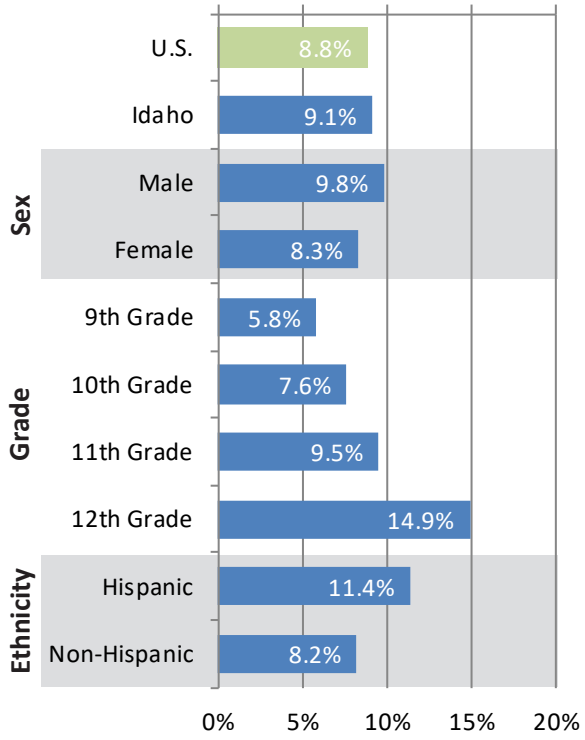
2011-2017

The percentage of obese adults in Idaho remained relatively unchanged since 2011. Idaho's overweight prevalence is similar to the **U.S.** median.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The percentage of adolescents in Idaho considered current cigarette smokers is lower than the U.S. rate. Some differences exist among demographic groups, but none of those differences (see chart below) are statistically significant.[1,2]



Current smoking among adolescents is defined as self-reported cigarette smoking on 1 or more days of the 30 days prior to being surveyed.

How Many Adolescents?

8,000

9% of Idaho adolescents (grades 9-12) currently smoke cigarettes

Who Are They?

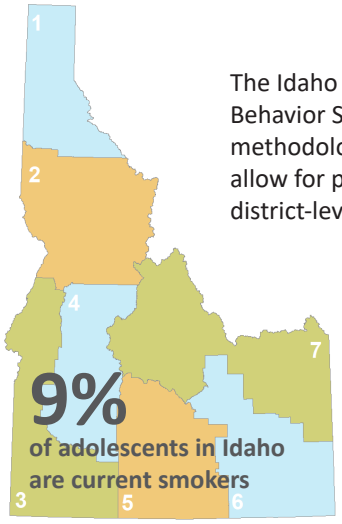
Older Students

Smoking increases slightly with grade-level

Hispanic Students

11% vs. 8% of non-Hispanic students are current smokers

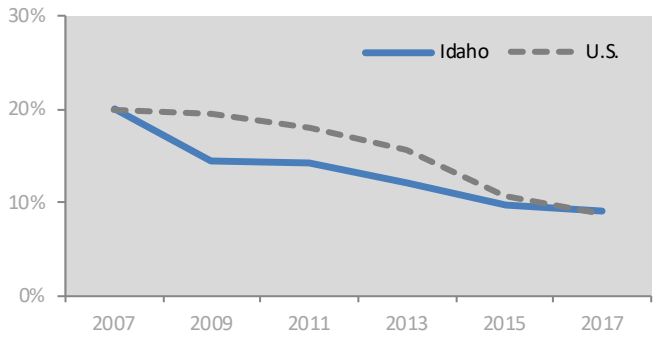
Where Are They?



The Idaho Youth Risk Behavior Survey (YRBS) methodology does not allow for public health district-level estimates

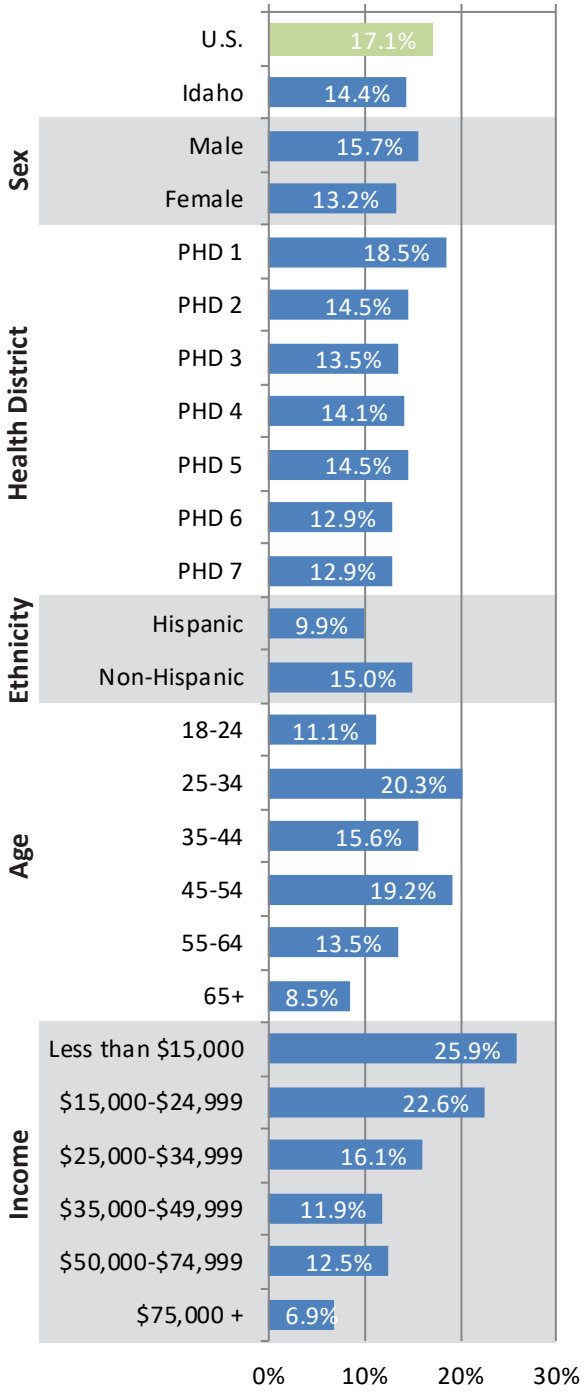
2007-2017

The percentage of adolescents in Idaho who are current smokers has decreased significantly since 2007. Idaho's cigarette smoking prevalence has been consistently lower than the U.S. rate over the past 10 years, however in 2017 they differed only slightly.[1,2]



1. Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.
2. Centers for Disease Control and Prevention (CDC). 1991-2017 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed December, 2017.

Cigarette smoking prevalence among **Idaho adults** is lower than the **U.S.** median. Some significant differences exist among demographic groups.[1]



Current smoking is defined as having previously smoked 100 or more cigarettes and smoking on any of the 30 days prior to being surveyed.

How Many Adults?

177,000
14% of Idaho adults are cigarette smokers

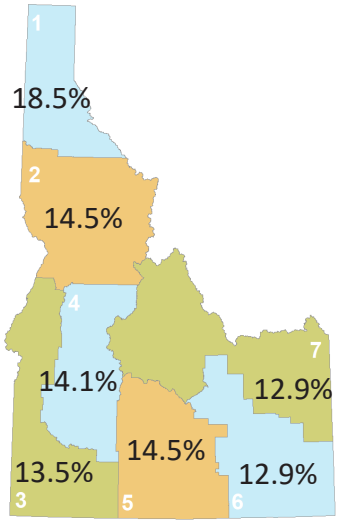
Who Are They?

Lower Income Adults
Smoking tends to increase as income decreases

Young Adults (25-34 years)
20% of adults aged 25-34 smoke cigarettes

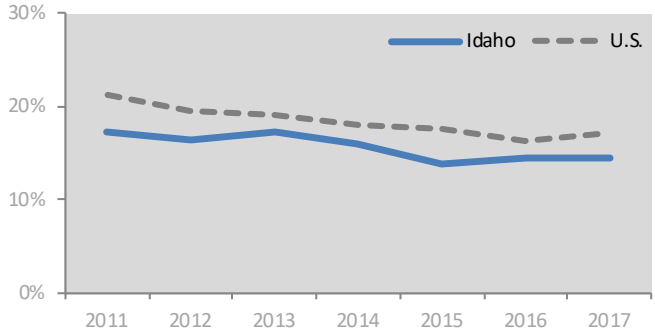
Non-Hispanic Adults
15% vs. 10% of Hispanic adults smoke cigarettes

Where Are They?



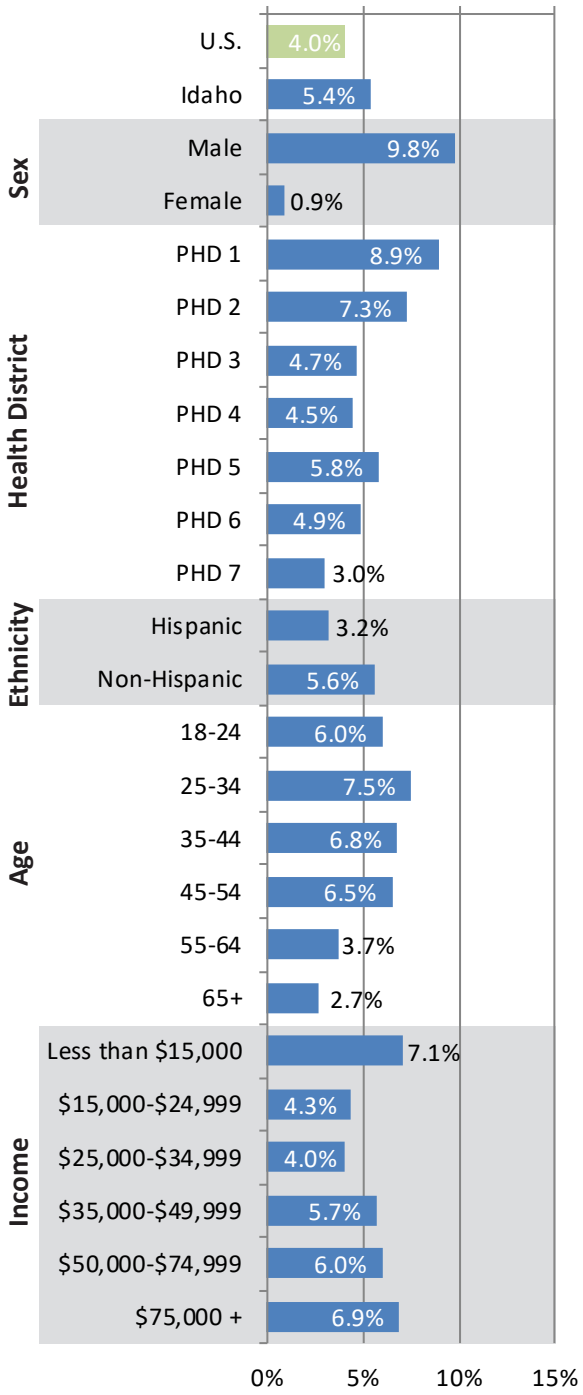
2011-2017

The percentage of adults in Idaho who smoke cigarettes decreased significantly since 2011. Idaho's smoking prevalence is lower than the **U.S.** median over the past 7 years.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The percentage of Idaho adults who are smokeless tobacco users is higher than the U.S. median. Some significant differences exist among the demographic groups listed below.[1]



Current smokeless tobacco use is defined as an adult who selects the response option of "every day" or "some days" to the question, "Do you currently use chewing tobacco, snuff, or snus?"

How Many Adults?

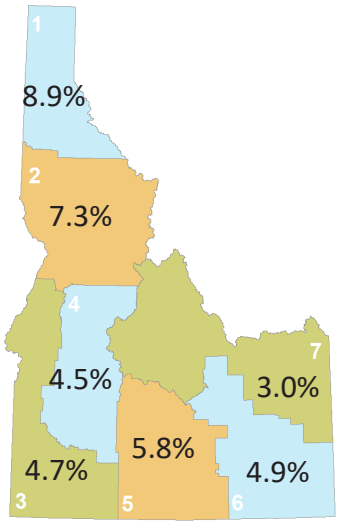
66,000
5% of Idaho adults are smokeless tobacco users

Who Are They?

Males
10% vs. 1% of females are smokeless tobacco users

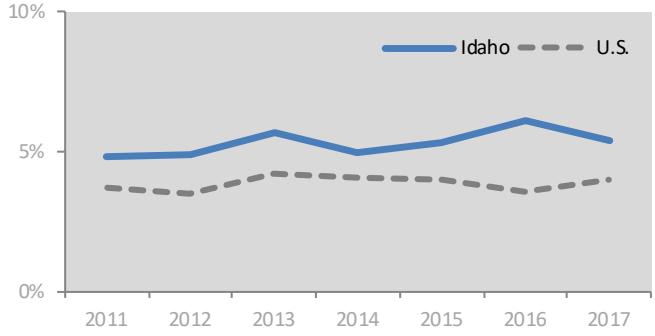
Non-Hispanic Adults
6% vs. 3% of Hispanics are smokeless tobacco users

Where Are They?



2011-2017

The percentage of adults in Idaho who use smokeless tobacco has remained relatively unchanged since 2011. Idaho's smokeless tobacco prevalence has been higher than the U.S. **median** since 2011.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

DTaP Immunization

The DTaP vaccine includes components that protect against diphtheria, tetanus, and pertussis.

The four-dose DTaP series is recommended to be administered at 2, 4, 6, and 15-18 months of age.

An additional booster dose of DTaP is recommended at 4-6 years of age (approximately at school-entry age).

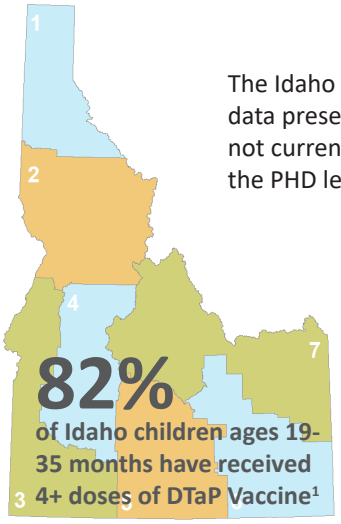
How Many Children Are Not Immunized?

18%

of Idaho children (ages 19-35 months) have **not** received 4+ doses of DTaP vaccine[1]

Note: a population estimate is not available for this measure.

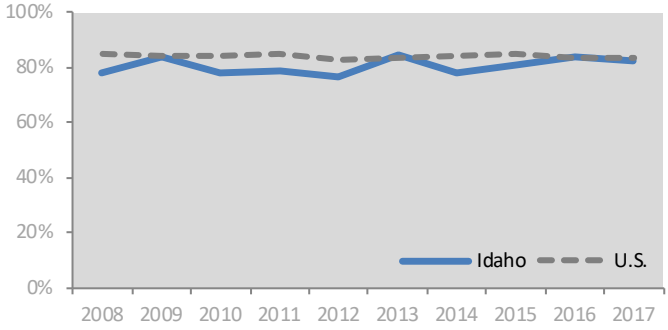
Where Are They?



The Idaho immunization data presented here are not currently available at the PHD level.

2008-2017

The percentage of children in Idaho (age 19-35 months) who received 4+ doses of the DTaP vaccine has remained relatively unchanged since 2007. Idaho's DTaP immunization rate has not been statistically different than the U.S. rate over the past 10 years.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Idaho Immunization Program. Idaho and National Immunization Rates Child National Immunization Survey Data for US and Idaho, 2006-2015. Available at http://www.healthandwelfare.idaho.gov/Portals/0/Health/Idaho%20Immunizations/Documents/2015%20Children%20NIS.pdf. Accessed December, 2018.

HPV Immunization

The Human Papillomavirus (HPV) vaccine routine administration schedule is to begin at 11 or 12 years, but as early as 9 years and be completed over the course of six months.

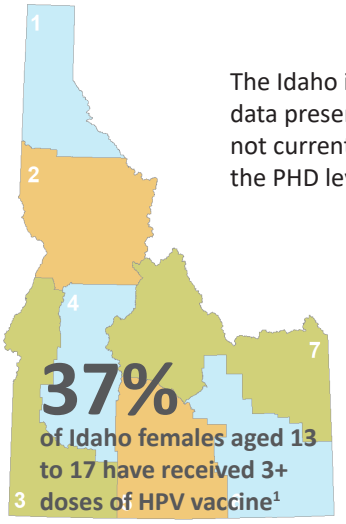
The quadrivalent HPV vaccine protects against two HPV strains that together account for 70% of cervical cancers. The other two components protect against HPV strains that cause other cancers and genital warts.

The 9-valent HPV (9vHPV) vaccine was approved by the FDA in December 2014. The additional five components included the 9vHPV vaccine increases the amount of strains protected against in about 90% of cervical cancers.

How Many Adolescent Females Are Not Vaccinated?

63%
of Idaho adolescent females (ages 13-17) have not received 3+ doses of HPV vaccination[1]
Note: a population estimate is not available for this measure.

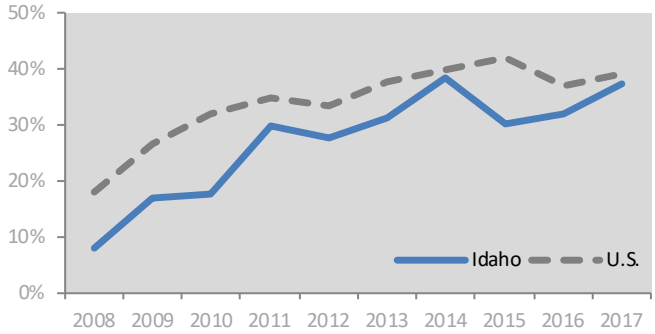
Where Are They?



The Idaho immunization data presented here are not currently available at the PHD level.

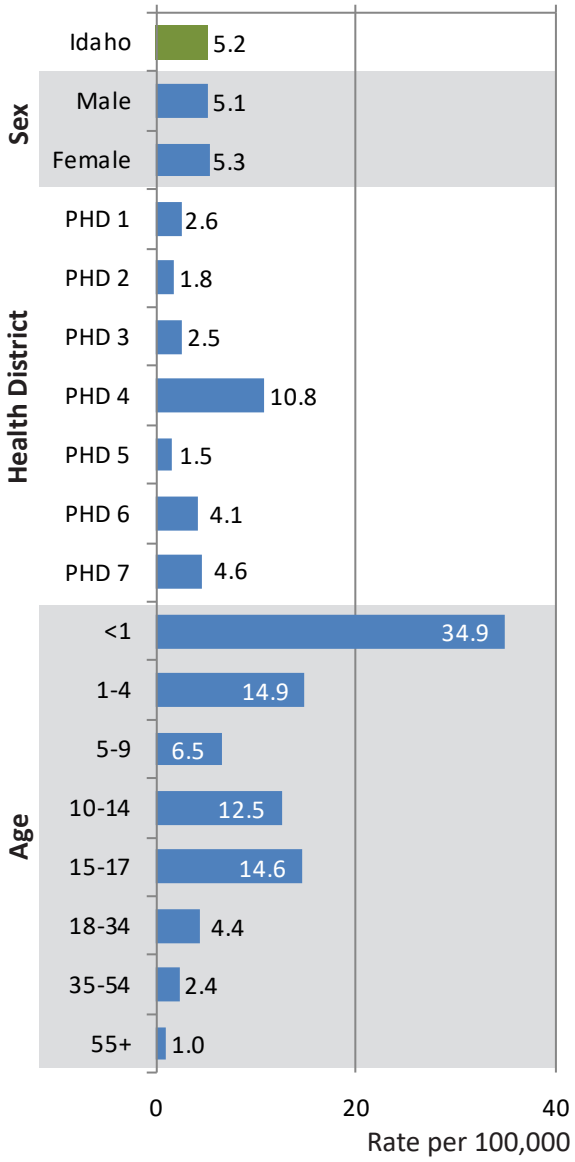
2008-2017

The percentage of females 13 to 17 years-of-age in Idaho who received 3+ doses of the HPV vaccine have been steadily rising since 2008 and have not differed significantly from the U.S. rate during that time.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Idaho Immunization Program. Idaho and National Immunization Rates Child National Immunization Survey Data for US and Idaho, 2006-2017. Available at http://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/index.html. Accessed December, 2018.

The incidence rate of pertussis differs significantly among some of the groups listed below.

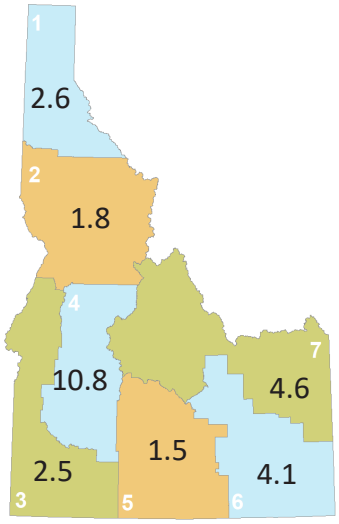


How Many Cases Reported?

89

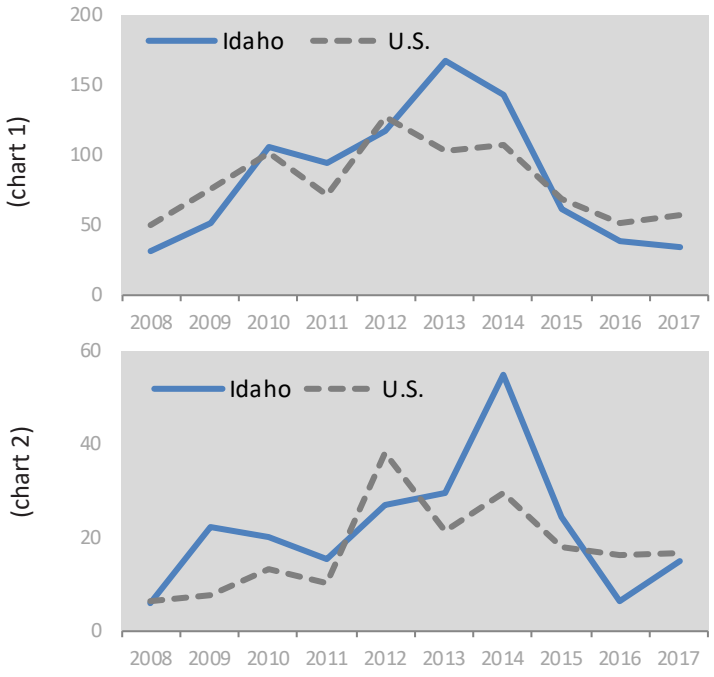
Cases of pertussis (whooping cough) were reported in 2017

Where Are They?



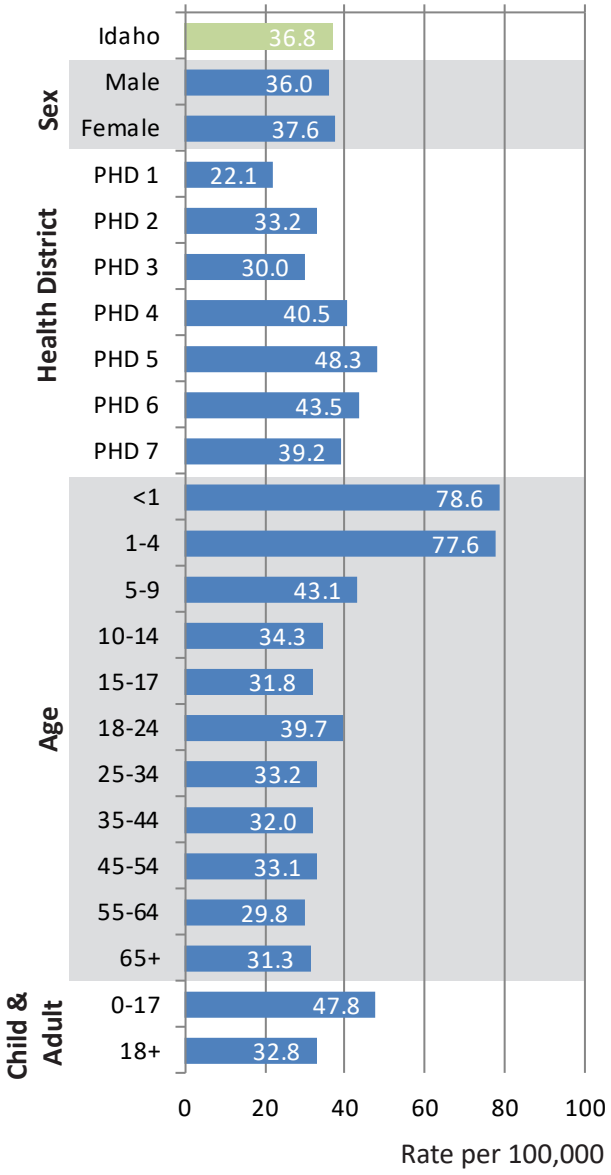
2008-2017

The incidence rate of pertussis in **Idaho** among **infants <1 year of age** (chart 1) and **kids 11-18 years of age** (chart 2) varies from year to year and peaks every 3 to 5 years. Idaho's pertussis incidence rate trend has been similar to the **U.S.** rates over the past 10 years.



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Communicable Disease Prevention, Epidemiology Program. Pertussis Incidence Rates 2007-2017. Special request December, 2018.

The incidence rate (per 100,000) of specified enteric diseases reported to public health in Idaho includes reported cases of cryptosporidiosis, giardiasis, listeriosis, salmonellosis, shiga toxin-producing *Escherichia coli* (STEC), and shigellosis.[1]



How Many Cases Reported?

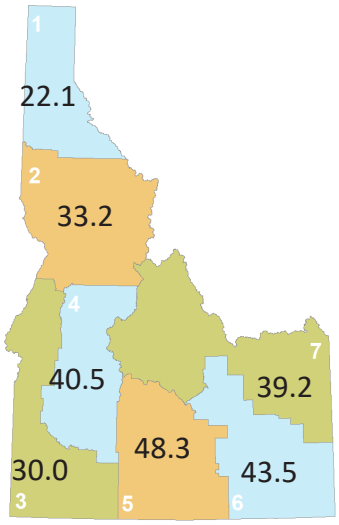
632

cases of enteric diseases were reported to public health in Idaho during 2017 (36.8 per 100,000 persons)

Enteric Outbreaks

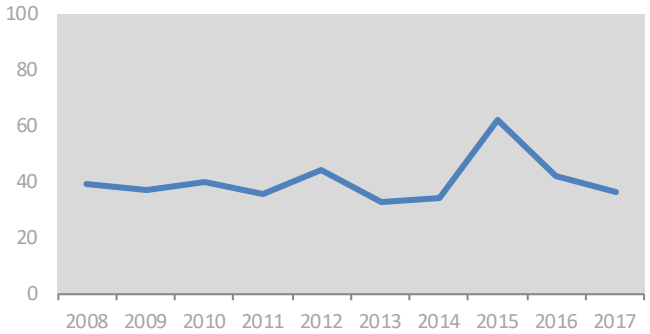
Outbreaks of enteric diseases occur every year. In 2017, approximately one-third (32.9%) of all cases of enteric illness reported to public health officials in Idaho were associated with an outbreak.

Where Are They?



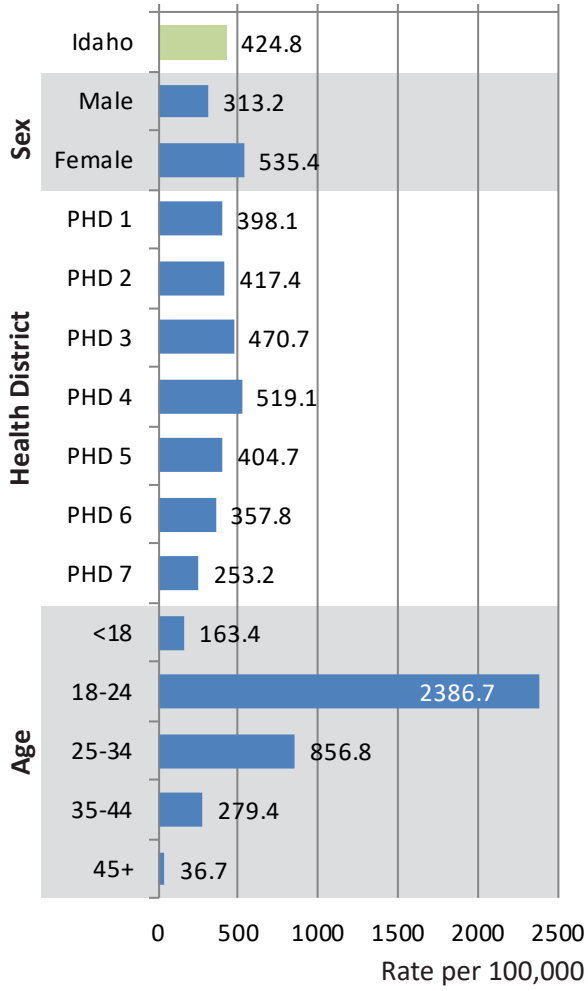
2008-2017

The incidence rate of enteric diseases reported to public health in **Idaho** peaked in 2015.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Communicable Disease Prevention, Epidemiology Program. Enteric diseases Incidence Rates 2008-2017. Special request November, 2018.

The incidence rate (per 100,000) of STDs reported to public health in **Idaho** includes reported cases of chlamydia, gonorrhea, or syphilis. Females and young adults in Idaho have the highest risk for contracting one of these STDs.[1]



How Many Cases?

7,294

Cases of chlamydia, gonorrhea, or syphilis were reported in 2017

Who Are They?

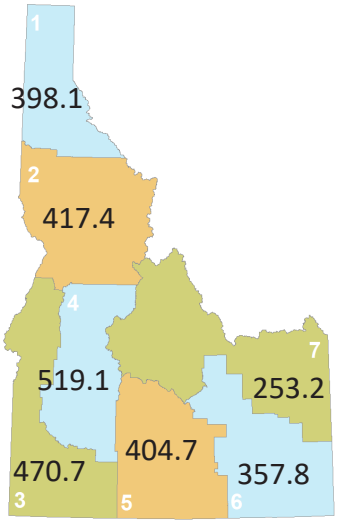
Females

Females are nearly twice as likely as men to be diagnosed with chlamydia, gonorrhea, or syphilis

Young Adults (18-24 years)

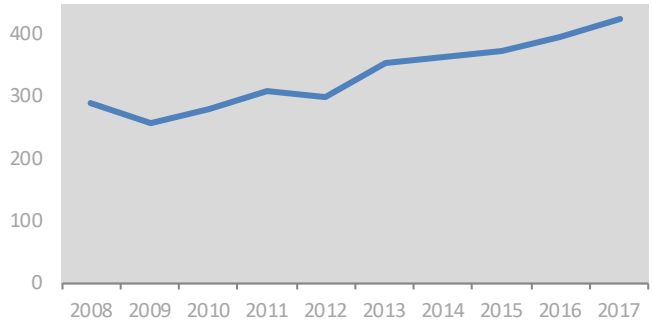
Idahoans aged 18 to 24 are significantly more likely to be diagnosed with and STD than older adults

Where Are They?



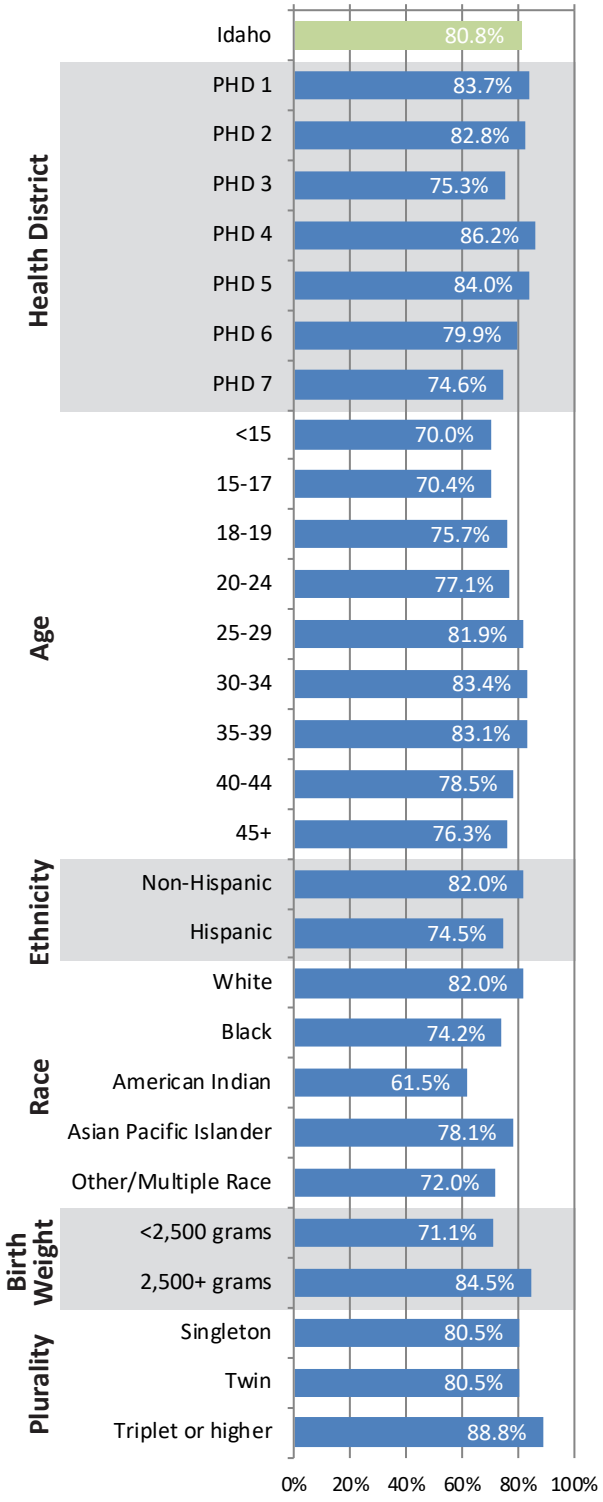
2008-2017

The incidence rate of STDs has increased significantly since 2008. The increase in the overall rate can be attributed to increases in all three STDs (chlamydia, gonorrhea, and syphilis). The equivalent U.S. rate is not available, but U.S. rates of all 3 STDs have increased significantly during the same time-period.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Communicable Disease Prevention, Epidemiology Program. Sexually Transmitted Disease Incidence Rates 2005-2017. Special request - November, 2018.

The percentage of mothers who received adequate (or more) prenatal care in Idaho differs among some of the demographic groups listed below.[1]



Adequate prenatal care is defined as initiating prenatal care in the first trimester with nine or more visits.

How Many Mothers?

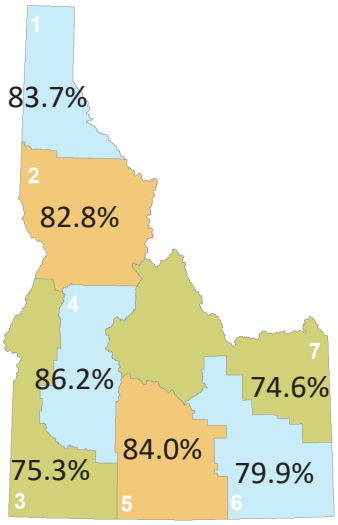
17,691
Idaho mothers received adequate prenatal care vs. 4,206 who did **not** receive adequate prenatal care in 2017

Who Are They?

Young Mothers
Younger mothers (<15 to 18 years) are less likely to receive adequate prenatal care

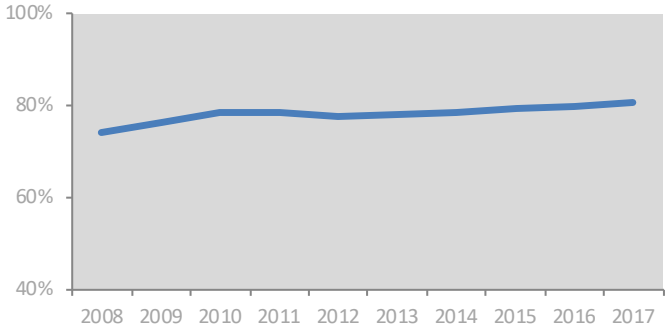
American Indian Mothers
62% vs. 82% of White mothers received adequate prenatal care

Where Are They?



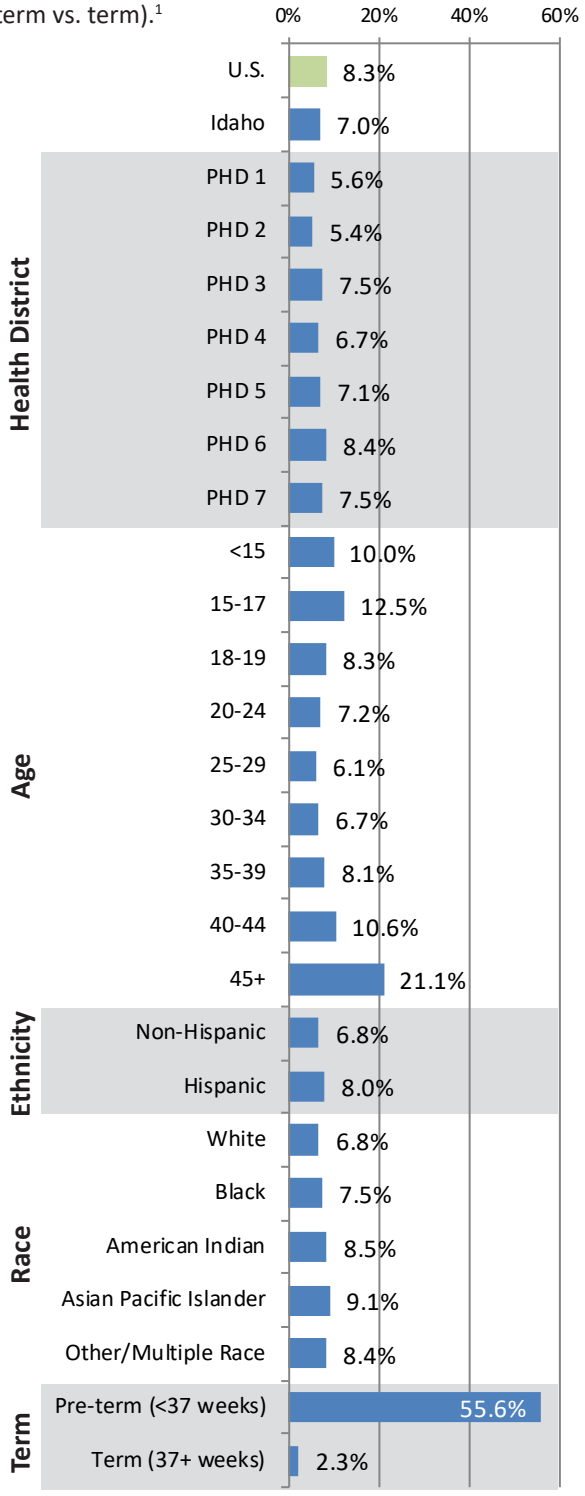
2008-2017

The percentage of mothers in Idaho who received adequate (or more) prenatal care has remained relatively unchanged since 2007.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

Low birthweight births in **Idaho do not** differ significantly from the **U.S.** rate. There are some differences seen among age of mother and term (pre-term vs. term).[1]



Low birthweight is defined as a birth weight of less than 2,500 grams.

How Many Low Birthweight Births?

1,552

Births were considered to be a low birthweight births (<2,500 grams) in 2017

Who Are They?

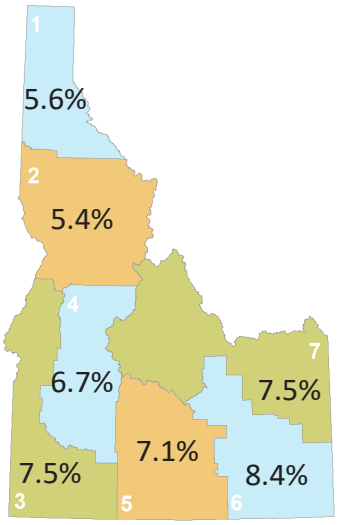
Younger and Older Mothers

Younger mothers (<18 years) and older mothers (45+ years) are more likely to have a low birthweight delivery

Pre-term births

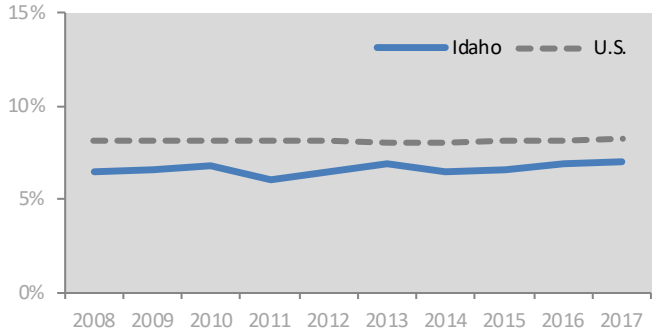
56% vs. 2% of full term births result in a low birthweight birth

Where Are They?



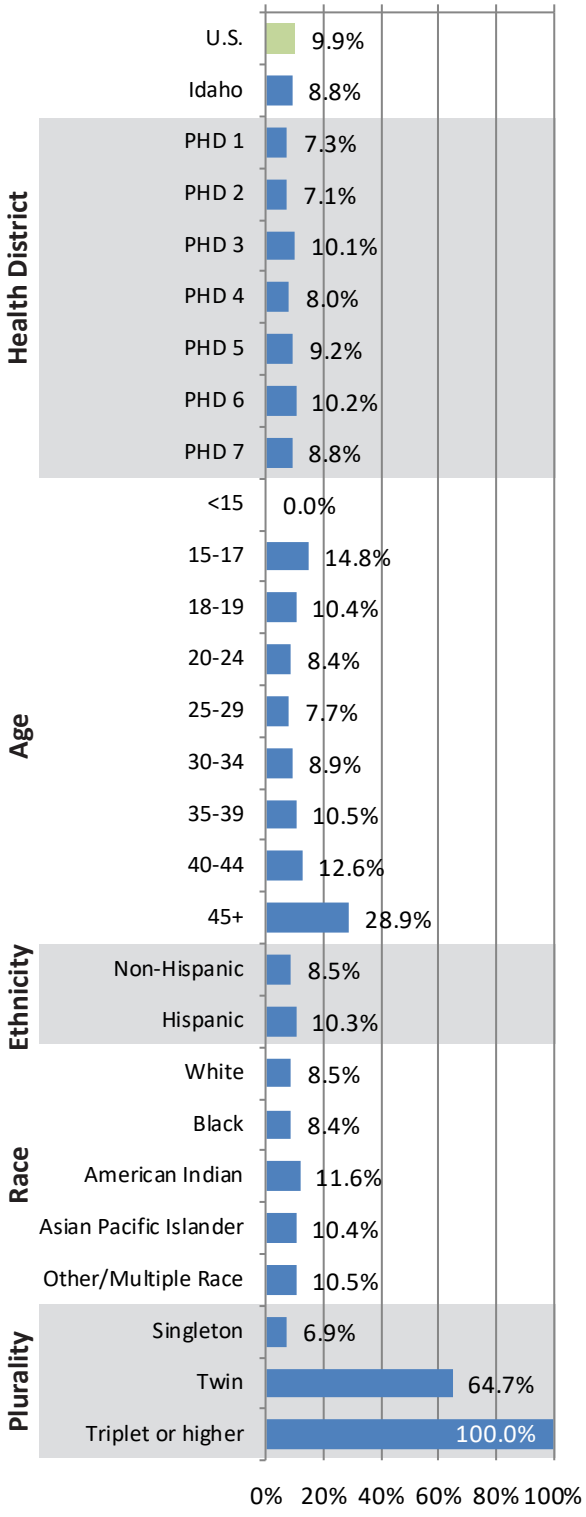
2008-2017

The percentage of low birthweight births in **Idaho** has remained relatively unchanged since 2007. Idaho's low birthweight rate has consistently been lower than the U.S. rate.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

The percentage of live births with a pre-term delivery among **Idaho mothers** differs significantly by age and plurality.[1]



How Many Pre-term Births?

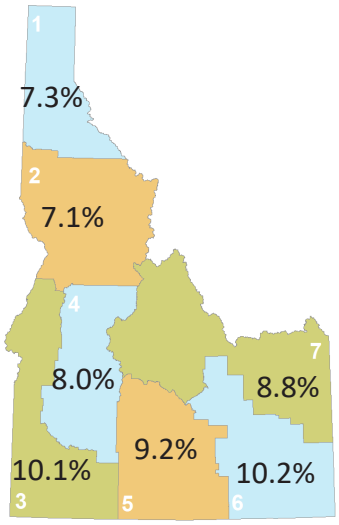
1,939
Pre-term deliveries (i.e., <37 weeks) in 2017

Who Are They?

Younger and Older Mothers
Younger (<18 years) and older (45+) mother's pregnancies are more likely to result in a pre-term birth

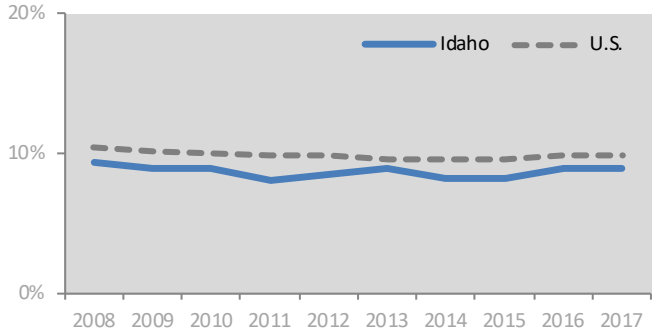
Twins, Triplets or Higher
65% (twins), 100% (triplets or higher) vs. 7% of singleton births

Where Are They?



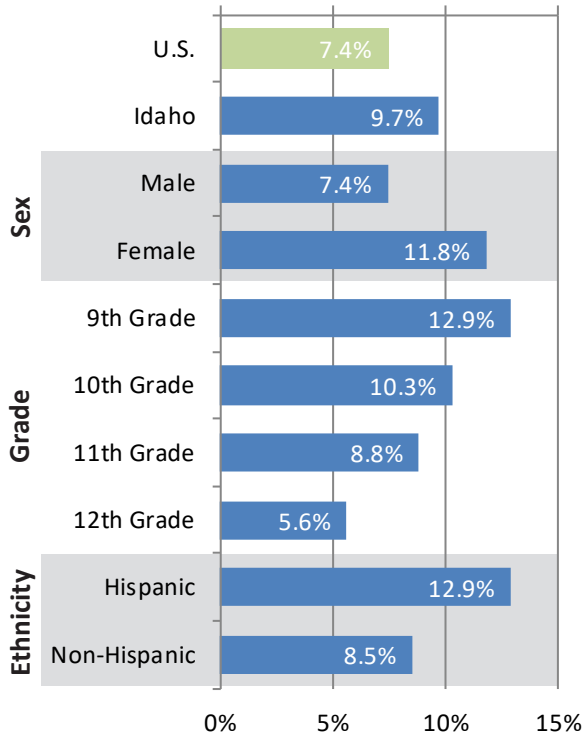
2008-2017

The percentage of Idaho resident births with a pre-term delivery has decreased slightly since 2007, and remains slightly lower than the U.S. pre-term delivery rate.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

The percentage of Idaho adolescents who have attempted suicide does not differ significantly from the U.S. rate. The attempted suicide rate is significantly higher among female students (vs. male students).[1]



How Many Adolescents?

8,900

10% of Idaho adolescents (grades 9-12) have attempted suicide one or more times during the previous 12 months

Who Are They?

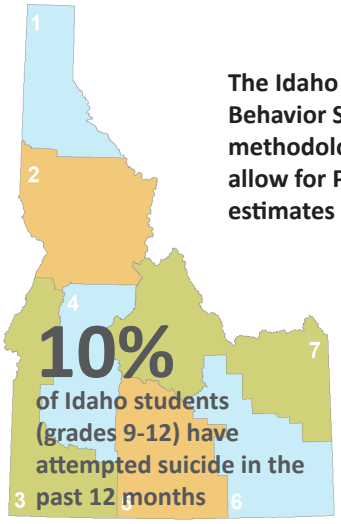
Female Students

12% vs. 7% of male students have attempted suicide

Hispanic Students

13% vs. 9% on non-Hispanic students have attempted suicide

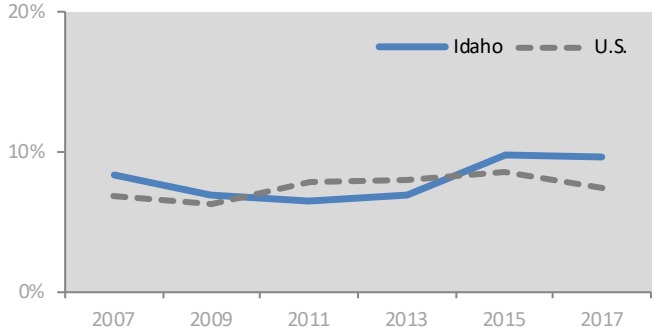
Where Are They?



The Idaho Youth Risk Behavior Survey (YRBS) methodology does not allow for PHD-level estimates

2007-2017

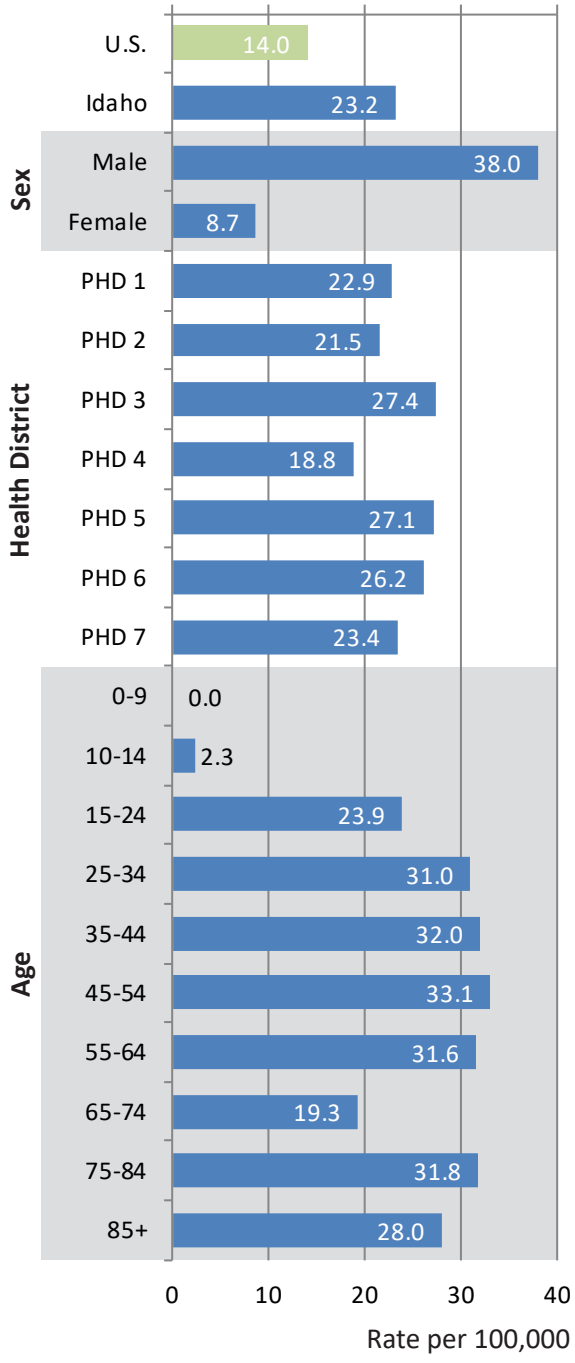
The percentage of adolescents in Idaho who have attempted suicide during the past 12 months has not changed significantly since 2007. Idaho's prevalence of suicide attempts has not differed significantly from the U.S. rate over the past 10 years.[1]



Idaho Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.

1. Centers for Disease Control and Prevention (CDC). 1991-2017 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed December, 2018.

The suicide death rate (age-adjusted) in **Idaho** is higher than the age-adjusted **U.S.** suicide death rate. Some highly significant differences exist between males and females and some age groups.[1]



How Many Suicide Deaths?

393

23 suicide deaths per 100,000 Idahoans

Who Are They?

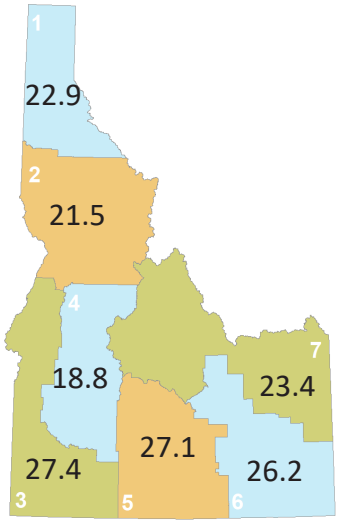
Males

38 per 100,000 vs. 9 per 100,000 females died by suicide

Middle Aged Adults (45-54 years)

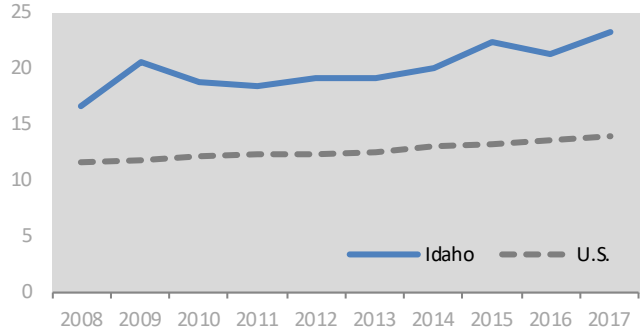
The age-specific suicide death rate is highest among adults aged 45 to 54 years

Where Are They?



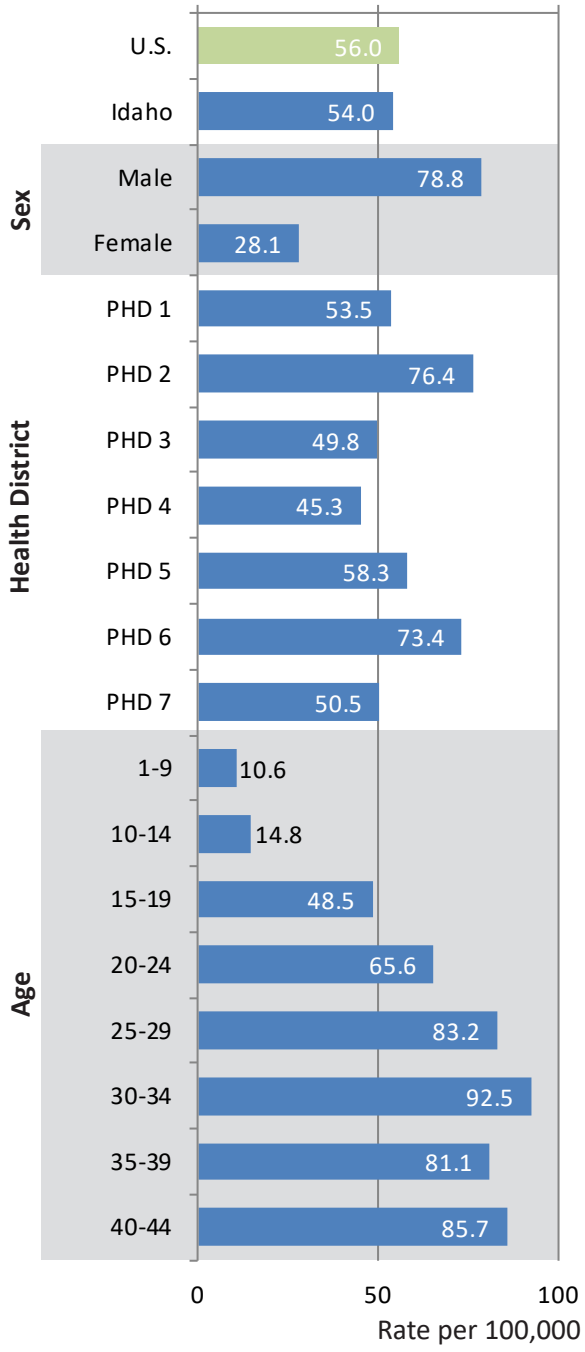
2008-2017

The age-adjusted suicide rate (per 100,000) among **Idaho** residents is significantly higher than the **U.S.** suicide rate over the past 10 years. The suicide death rate in **Idaho** has increased since 2008.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

Unintended Injury death rate (age-adjusted) **among Idahoans aged 1-44** is slightly higher than the **U.S.** unintentional injury death rate. Some significant differences exist between males and females and some age groups.[1]



How Many Unintentional Injury Deaths?

550

54 injury deaths per 100,000 Idahoans aged 1-44 years

Who Are They?

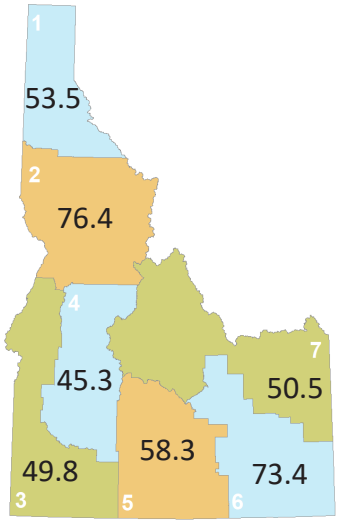
Males

79 per 100,000 males vs. 28 per 100,000 females died from an injury

Adults (25-39 years)

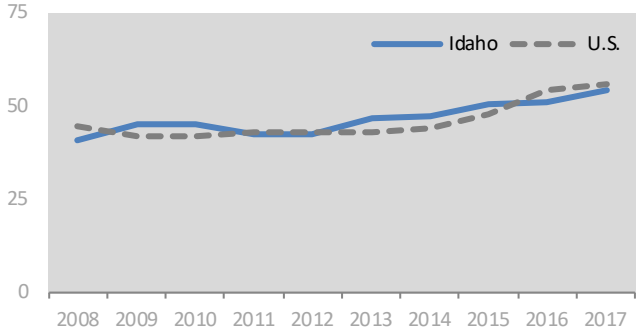
The injury death rate increases with age but is highest among adults 30 to 34 years

Where Are They?



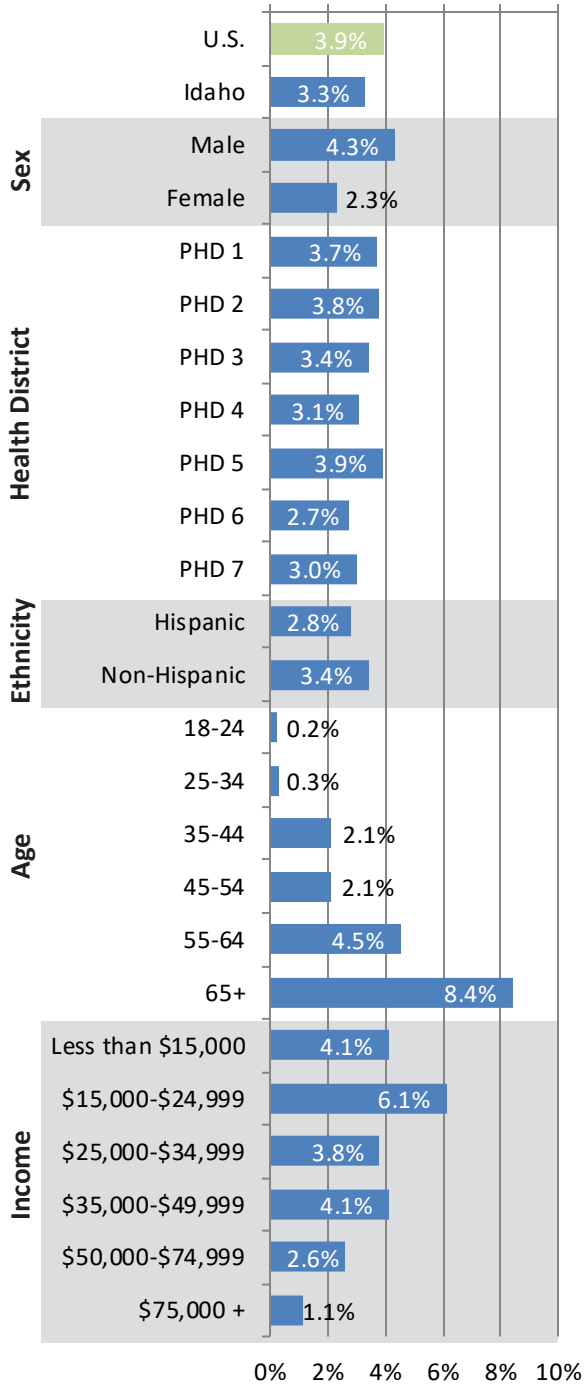
2008-2017

The injury death rate (per 100,000) among **Idaho** residents aged 1-44 is similar to the **U.S.** injury death rate over the past 10 years. The injury death rate in **Idaho** has not changed significantly since 2008.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

The prevalence of coronary heart disease among **Idaho adults** is slightly lower than the **U.S.** median. Some significant differences exist among demographic groups, particularly by age and income.[1]



How Many Adults?

42,000

3% of Idaho adults have been told by a health professional they have coronary heart disease

Who Are They?

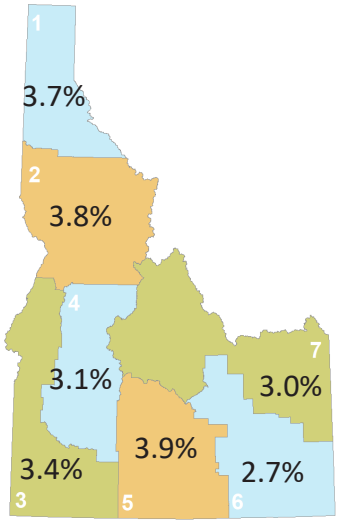
Income of $15,000 to $24,999

6% among those with incomes of $15,000 to $24,999

Older Adults (65+ years)

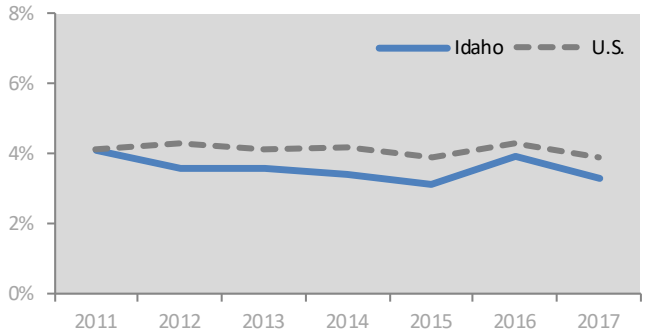
Adults age 65 and older are significantly more likely to be told they have coronary heart disease

Where Are They?



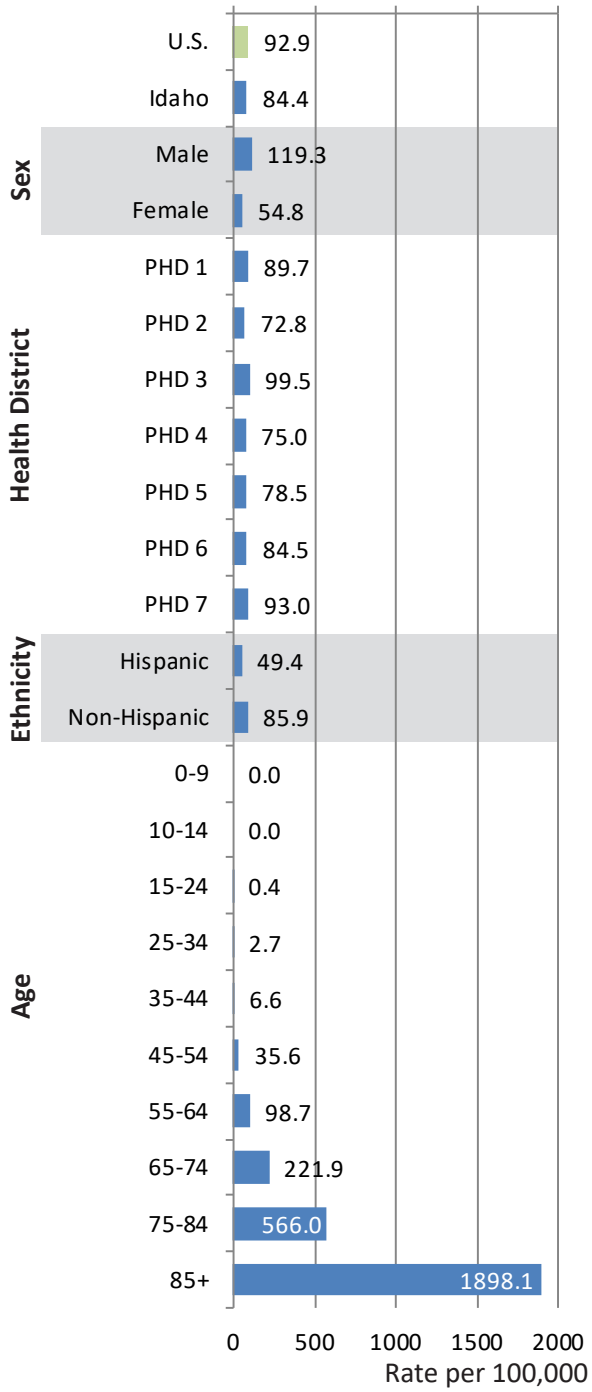
2011-2017

The percentage of adults in Idaho who have been told they have heart disease has remained relatively unchanged since 2011. Idaho's heart disease prevalence has been the same or slightly lower than the **U.S.** median over the past 7 years.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The rate of coronary heart disease[1] deaths among **Idahoans** does not differ significantly from the **U.S.** rate. Older adults are significantly more likely to die from coronary heart disease.[2]



How Many Adults?

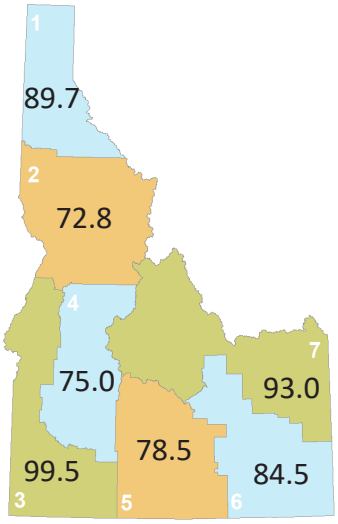
1,628
Idahoans died from coronary heart disease (84 per 100,000) in 2017

Who Are They?

Males
119 per 100,000 males vs. 55 per 100,000 females died from coronary heart disease

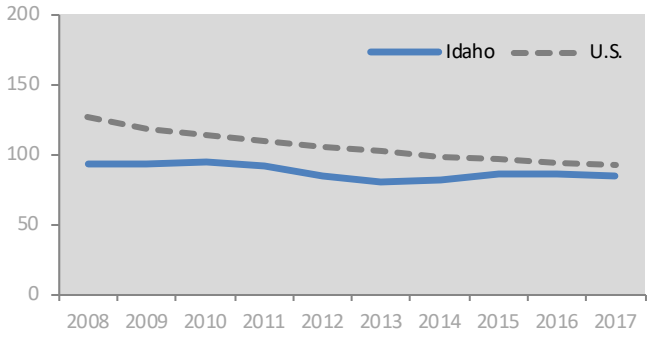
Older Adults (65+ years)
Coronary heart disease death rate increases significantly with age

Where Are They?



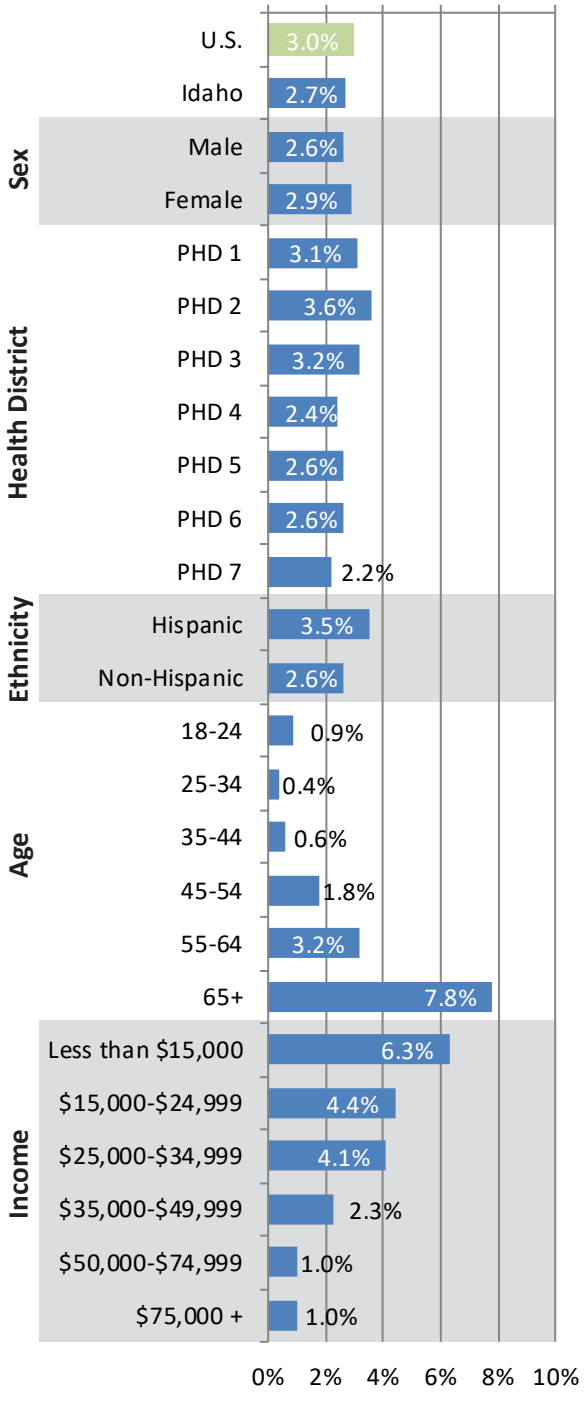
2008-2017

The coronary heart disease death rate in **Idaho** has decreased significantly since 2008. Idaho's heart disease death rate has also been significantly lower than the **U.S.** rate over the past 10 years.[2]



1. Coronary (Ischemic heart diseases) based on International Classification of Diseases (ICD-10) codes I20-I25.
2. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

Stroke prevalence among **Idaho adults** is slightly lower than the **U.S.** median. Some significant differences exist among demographic groups, particularly by age and income.[1]



How Many Adults?

35,000
3% of Idaho adults have had a stroke

Who Are They?

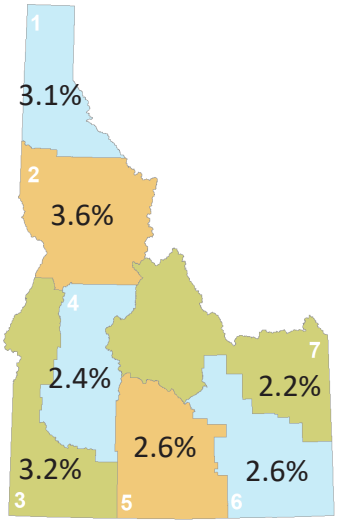
Older Adults (65+ years)

Adults age 65 and older are more likely to have had a stroke

Lower Income

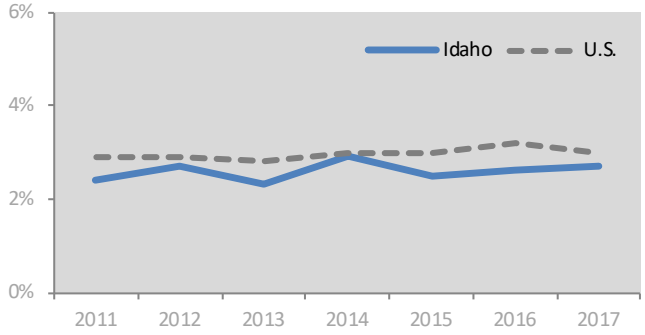
Lower income adults are more likely to have had a stroke

Where Are They?



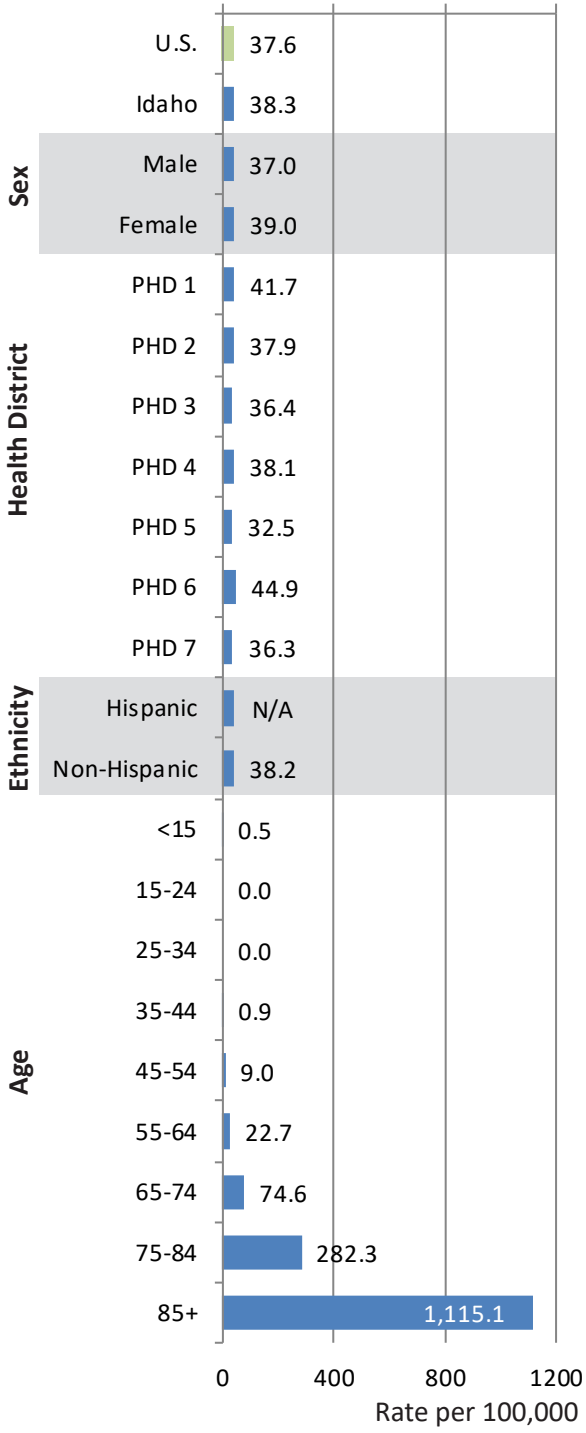
2011-2017

The percentage of adults in Idaho who have ever had a stroke has remained relatively unchanged since 2011. Idaho's heart disease prevalence has been lower than the **U.S.** rate since 2011.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The rate of stroke deaths among **Idahoans** does not differ significantly from the **U.S.** rate. The age-specific stroke death rate increases significantly with age.[1]



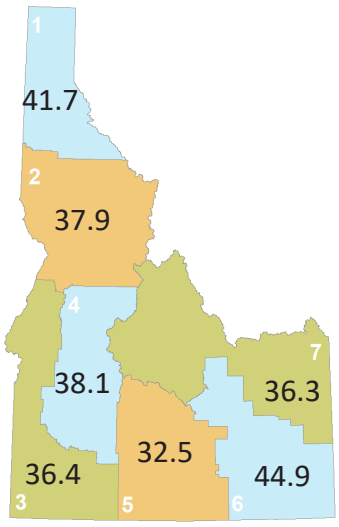
How Many Adults?

722
Idahoans died from a stroke (38 per 100,000) in 2017

Who Are They?

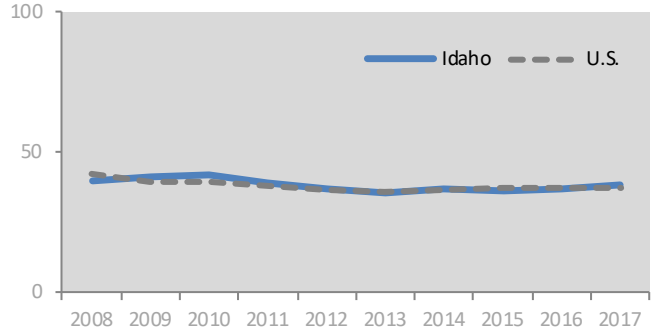
Older Adults (65+ years)
Stroke death rate increases significantly with age

Where Are They?



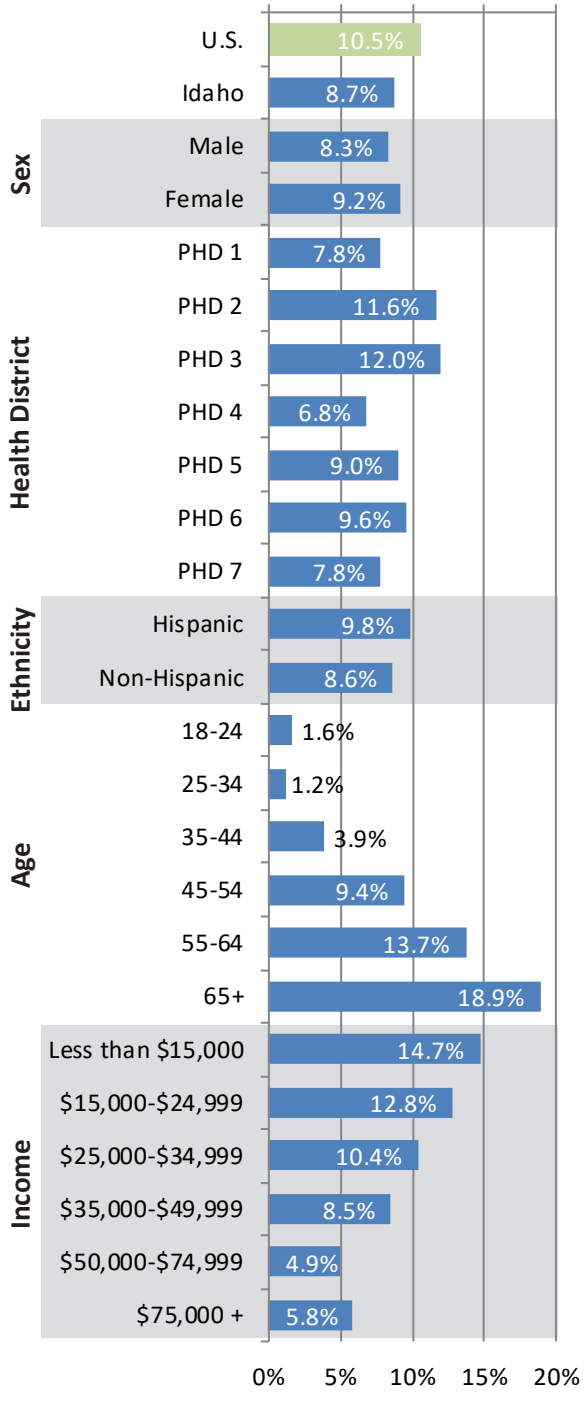
2008-2017

The stroke death rate in Idaho has decreased steadily since 2008. Idaho's stroke death rate has not differed significantly from the **U.S.** rate over the past 10 years.



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

The percentage of adults diagnosed with diabetes in **Idaho** is slightly lower than the **U.S.** median. Some significant differences exist among demographic groups, particularly by age and income.[1]



How Many Adults?

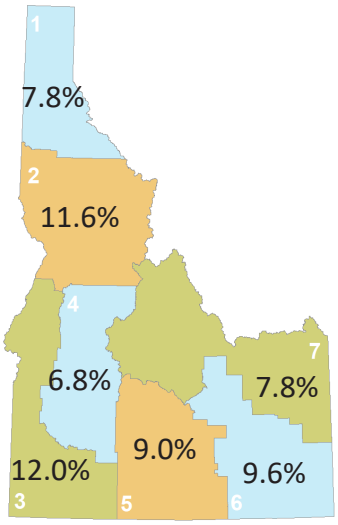
112,000
9% of Idaho adults have been diagnosed with diabetes

Who Are They?

Older Adults (65+ years)
The risk for diabetes increases significantly with age

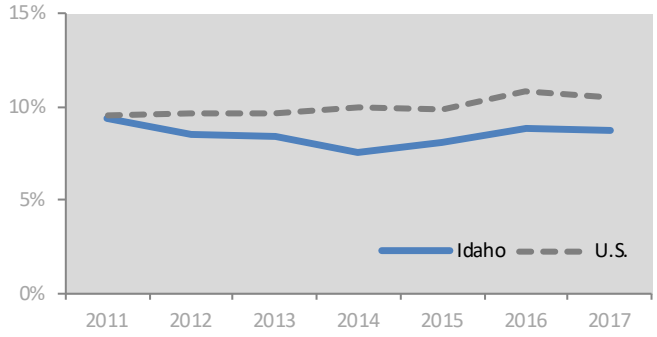
Income Below $25,000
Diabetes risk among adults with income of less than $25,000 is more than twice the risk of adults with income of $50,0000 or more

Where Are They?



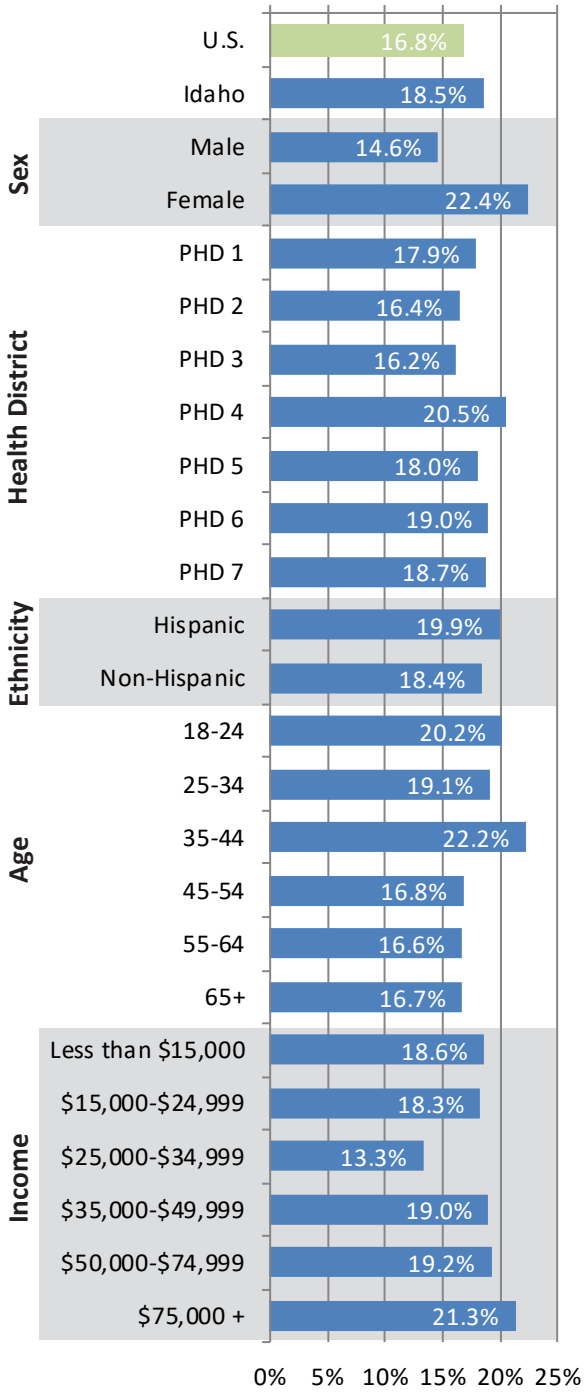
2011-2017

The percentage of adults in Idaho who have ever been diagnosed with diabetes remained unchanged from 2011 to 2017. Idaho's **diabetes** prevalence has been lower than the **U.S.** median since 2011.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The percentage of Idaho adults who consume 5 or more servings of fruits and vegetables a day is higher than the U.S. median. Some differences exist among demographic groups, particularly by sex and income.[1]



How Many Adults?

224,000

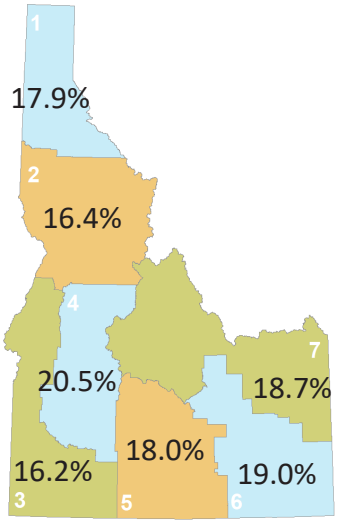
19% of Idaho adults consume 5 or more servings of fruits and vegetables a day

Who Are They?

Females

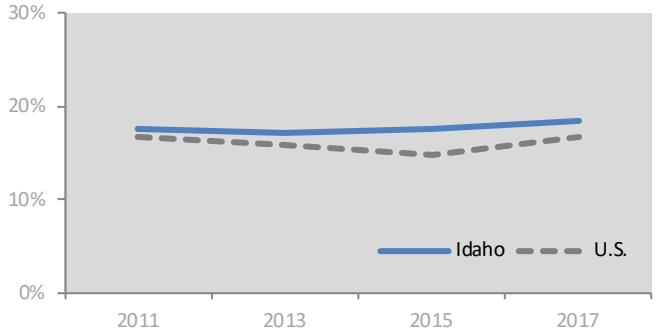
22% vs. 15% of males consume 5 or more servings of fruit and vegetables a day

Where Are They?



2011-2017

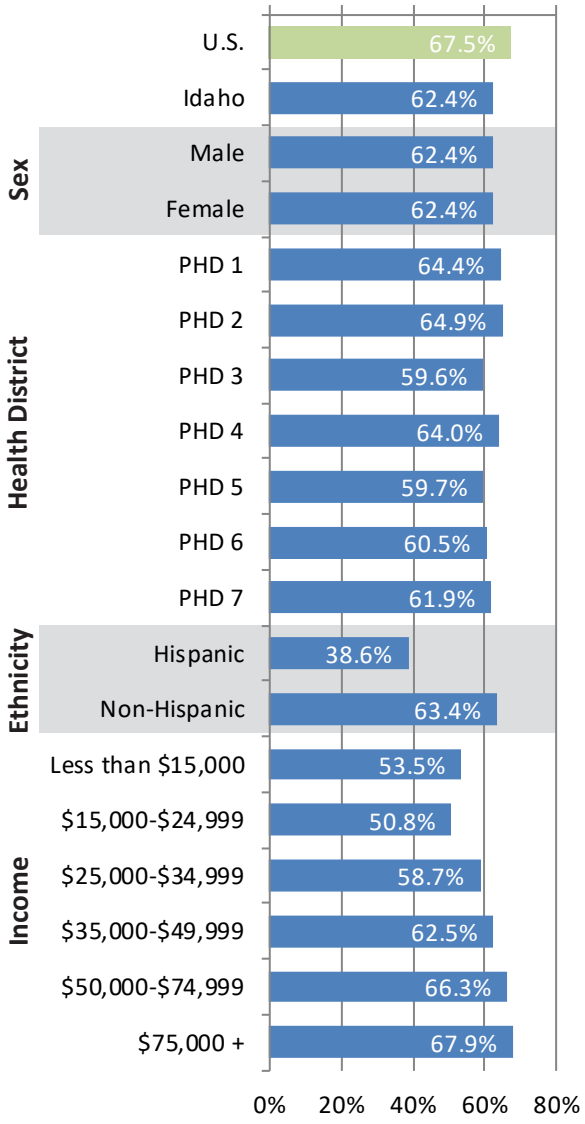
The percentage of adults in Idaho who consume 5 or more servings of fruits and vegetables a day did not change significantly between 2011 and 2017.[1]



Fruit and vegetable consumption questions are asked in odd-numbered years only.

1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The percentage of Idaho adults (age 50-75) who had colorectal cancer screening is lower than the U.S. median. Some significant differences exist among demographic groups, particularly by household income and Hispanic ethnicity.[1]



How Many Adults?

271,300

62% of Idaho adults (aged 50-75 years) have been screened for colorectal cancer

Who Are They?

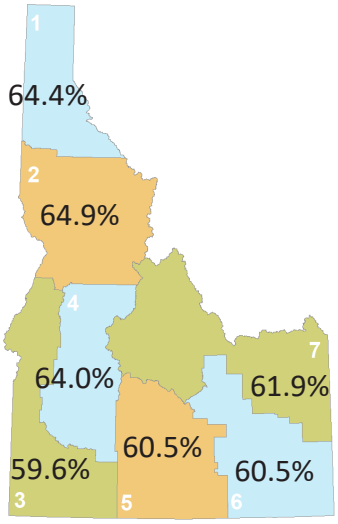
Hispanic Adults

39% vs. 63% non-Hispanic adults have been screened for colorectal cancer

Lower Income Adults

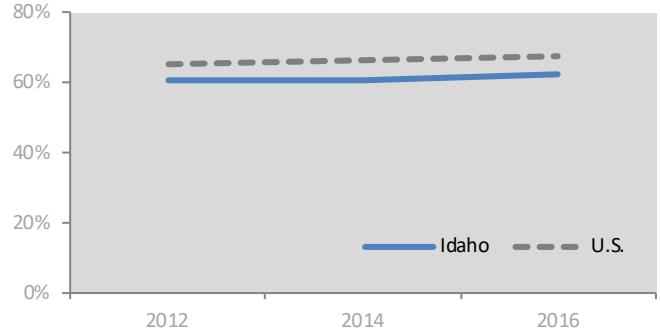
Colorectal cancer screening tends to decrease as income decreases

Where Are They?



2012-2016

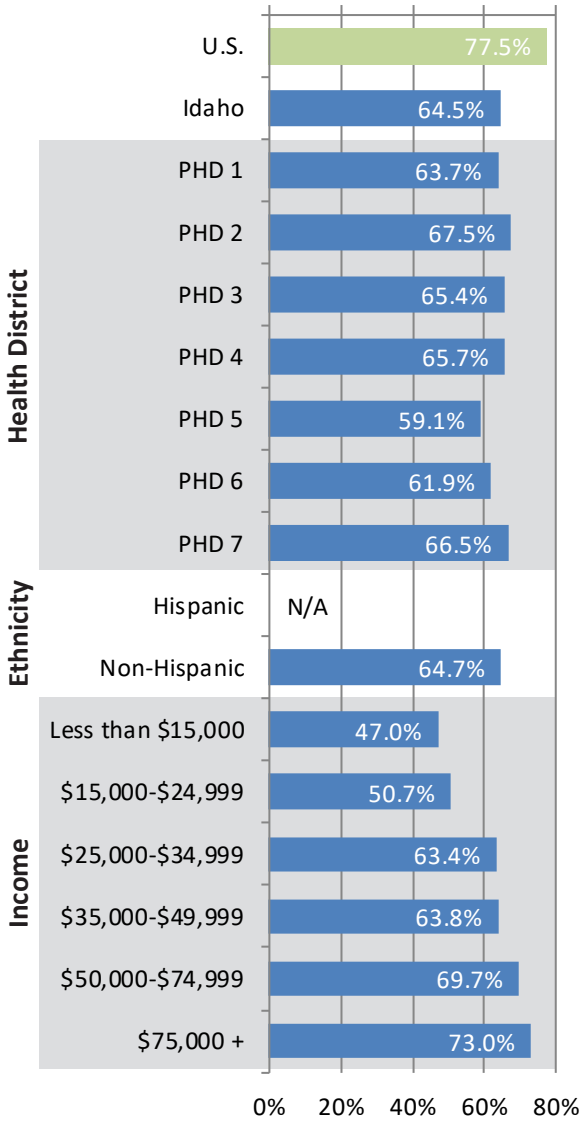
The percentage of adults in Idaho who have received colorectal cancer screening did not change significantly between 2012 and 2016[1]



Cancer screening questions are asked in even-numbered years only.

1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

The percentage of women (age 50-74) who had a breast cancer screening according to the most recent guidelines in Idaho is markedly lower than the U.S. median.



How Many Women?

144,000

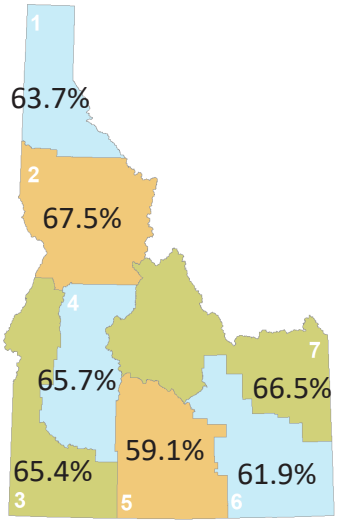
65% of female adults in Idaho (aged 50-74 years) have been screened for breast cancer based on the most recent guidelines

Who Are They?

Lower Income Females

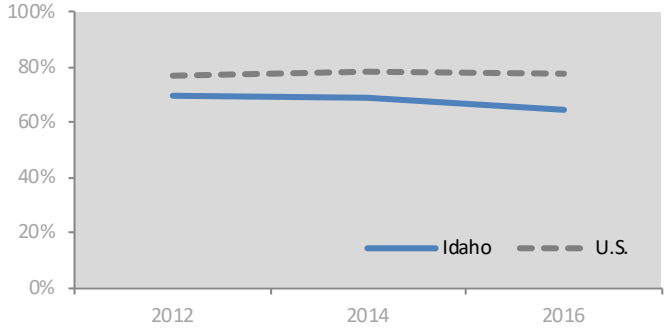
Are less likely to have been screened for breast cancer

Where Are They?



2012-2016

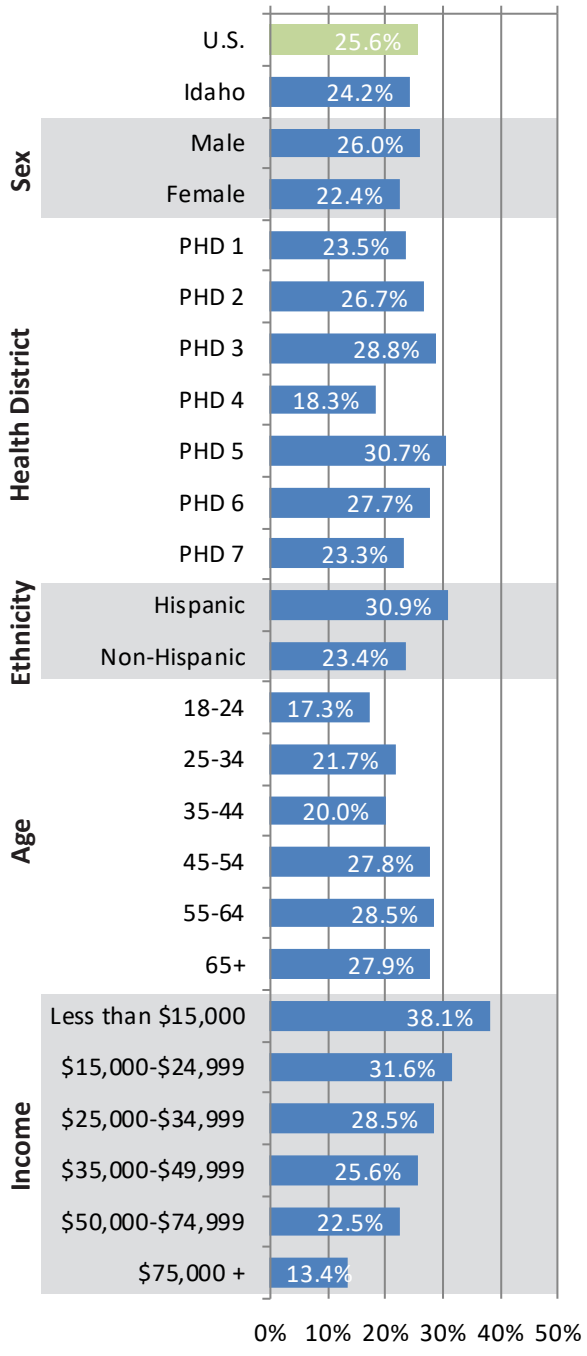
The percentage of adult females in Idaho who have received breast cancer screening did not change significantly between 2012 and 2016. Idaho's breast cancer screening rates were lower than the U.S. median for 2012 to 2016.[1]



Cancer screening questions are asked in even-numbered years only.

1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

The prevalence of Idaho adults with no leisure time physical activity is lower than the U.S. median. Some significant differences exist among demographic groups, particularly by income and Hispanic ethnicity.[1]



How Many Adults?

287,000

24% of Idaho adults did **not** participate in leisure time physical activity

Who Are They?

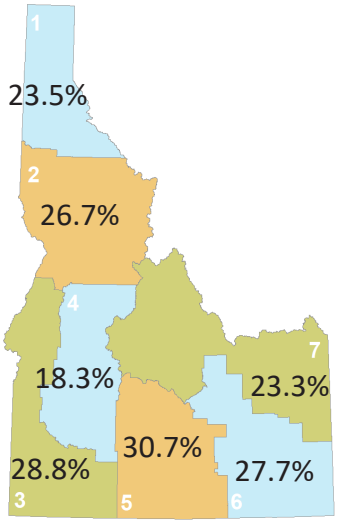
Hispanic Adults

31% vs. 23% of non-Hispanic adults did **not** participate in leisure time physical activity

Lower Income Adults

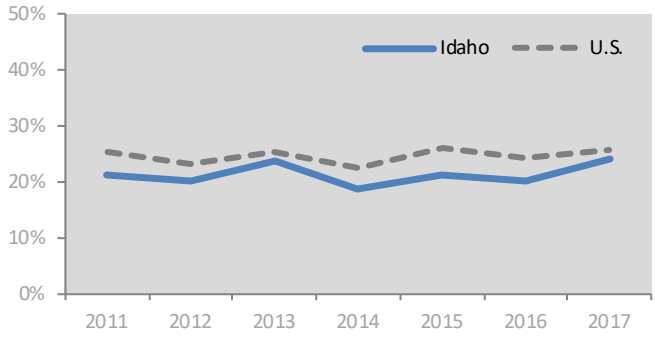
Are more likely to report they do not participate in leisure time physical activity

Where Are They?



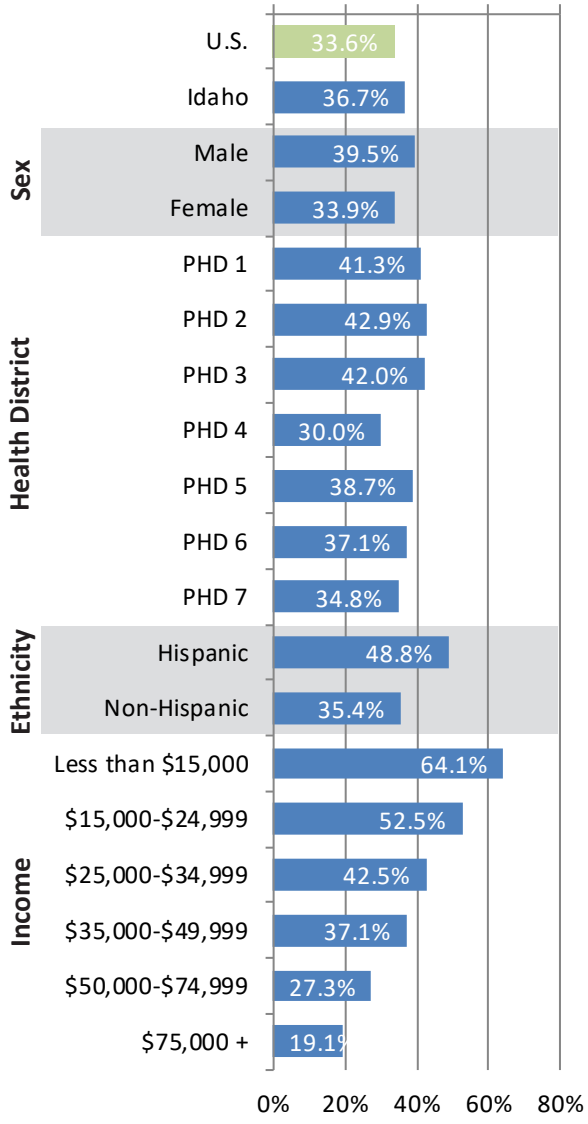
2011-2017

The percentage of adults in Idaho with no leisure time physical activity did not change significantly between 2011 and 2017.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

The prevalence of Idaho adults who did not visit the dentist in the past 12 months is slightly higher than the U.S. median. Some significant differences exist among demographic groups, particularly by sex, income, and Hispanic ethnicity.[1]



How Many Adults?

455,900

37% of Idaho adults did not visit a dentist in the past 12 months

Who Are They?

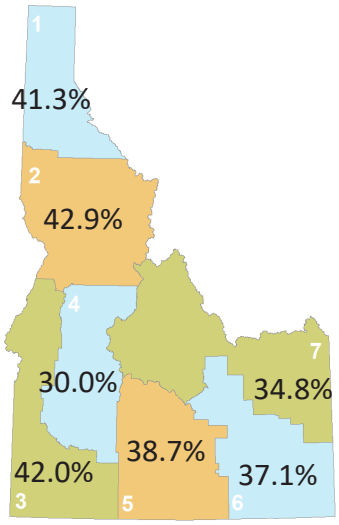
Hispanic Adults

49% vs. 35% non-Hispanic adults have not visited a dentist in the past 12 months

Lower Income Adults

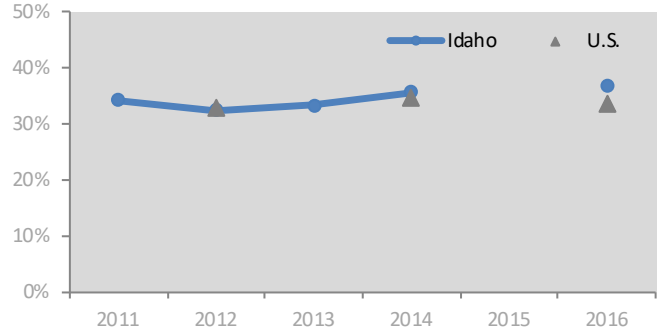
The percentage of adults who did not visit a dentist in the past 12 months increases as income decreases

Where Are They?



2011-2016

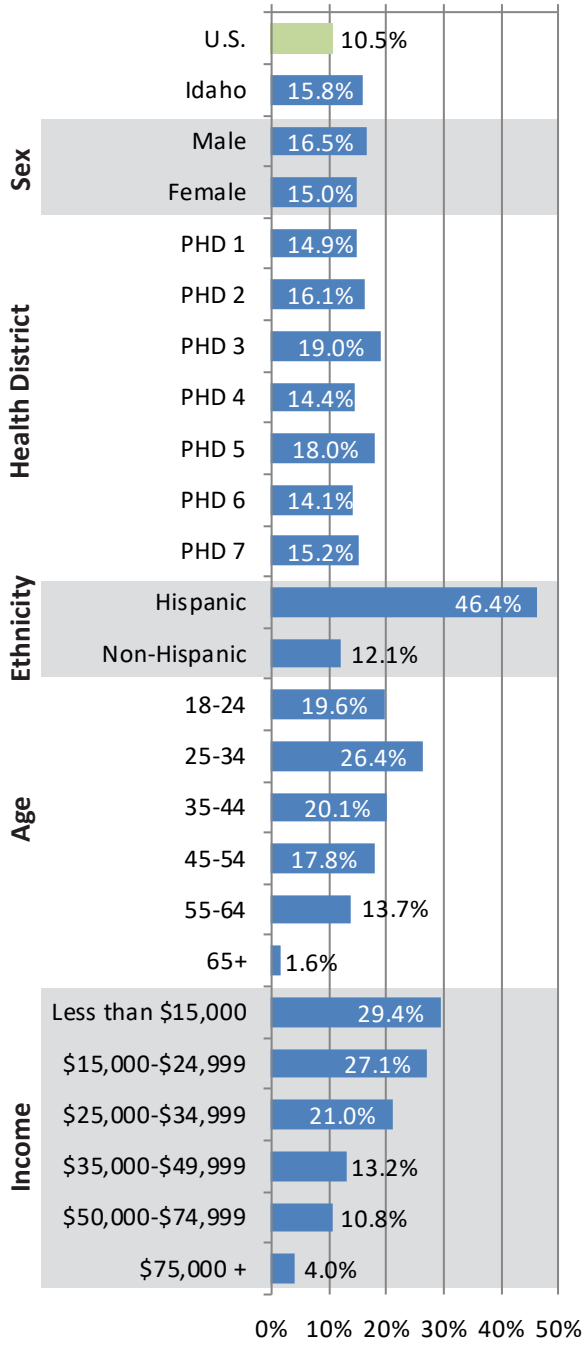
The percentage of adults in Idaho who did not visit a dentist during the past 12 months increased significantly between 2011 and 2016.[1]



The question about dentist visits was not asked in 2017.

1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2017.

The prevalence of Idaho adults who are without healthcare coverage is higher than the U.S. median. Some significant differences exist among demographic groups, particularly by income and Hispanic ethnicity.[1]



How Many Adults?

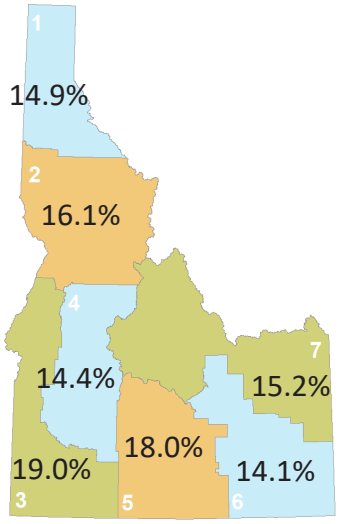
202,000
16% of Idaho adults do not have healthcare coverage

Who Are They?

Hispanic Adults
46% vs. 12% non-Hispanic adults do not have healthcare coverage

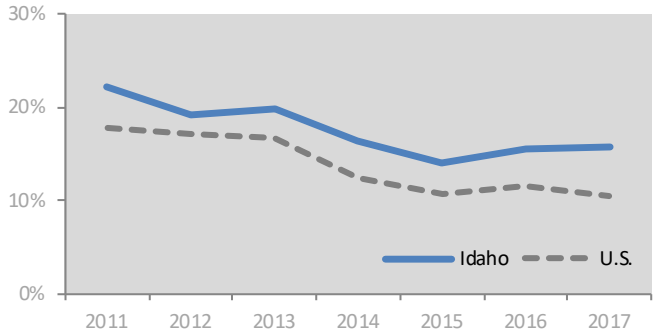
Lower Income Adults
Are significantly less likely to have healthcare coverage

Where Are They?



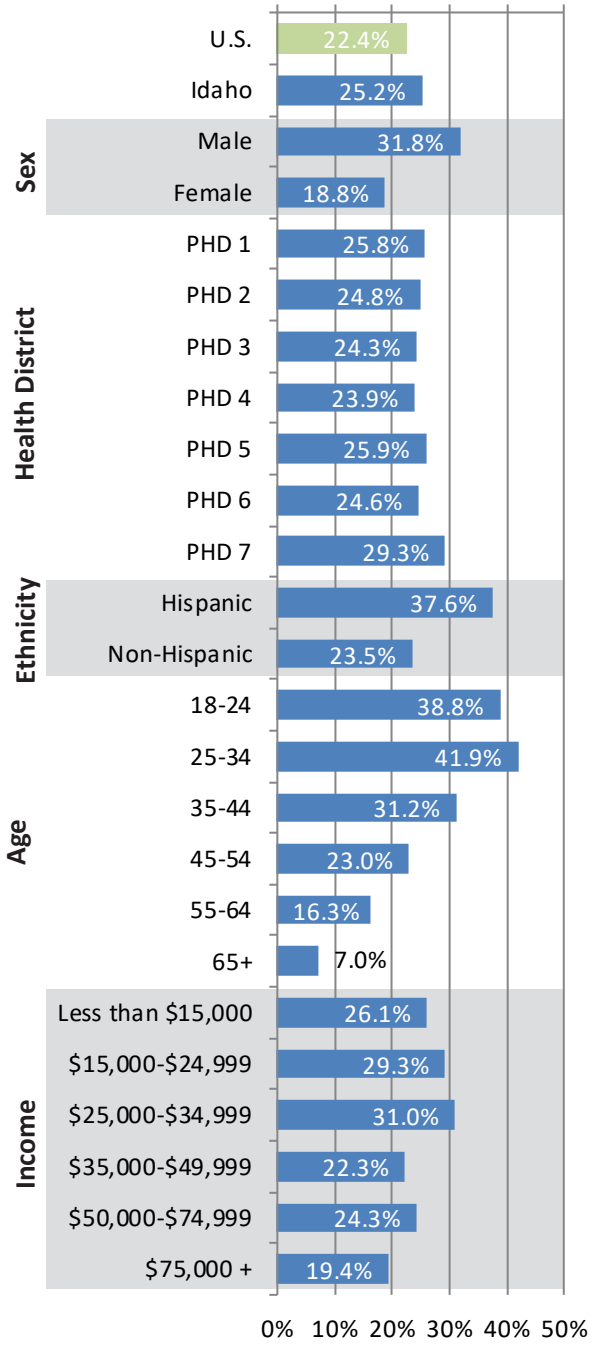
2011-2017

The percentage of adults in Idaho who do not have healthcare coverage decreased significantly between 2011 and 2017.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018

The prevalence of Idaho adults who do not have a usual healthcare provider is higher than the U.S. median. Some significant differences exist among demographic groups, particularly by sex, income and Hispanic ethnicity.[1]



How Many Adults?

322,000

25% of Idaho adults do not have a usual healthcare provider

Who Are They?

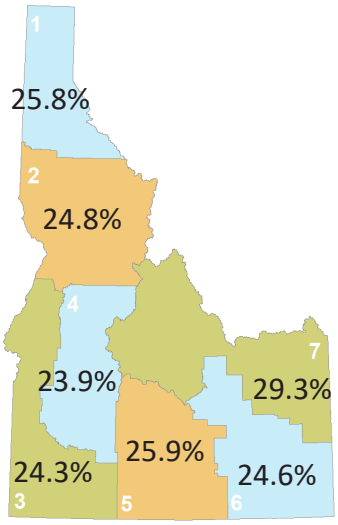
Hispanic Adults

38% vs. 24% non-Hispanic adults do not have a usual healthcare provider

Males

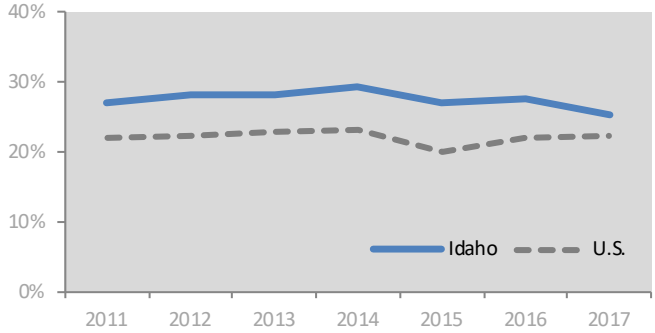
32% vs. 19% of females do not have a usual healthcare provider

Where Are They?



2011-2017

The percentage of adults in Idaho who do not have a usual healthcare provider remained unchanged between 2011 and 2017.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Behavioral Risk Factor Surveillance System, 2018.

Primary Care Physicians

Idaho ranked 46th (i.e., 4th lowest among all 50 states) for the number of active primary care physicians (73.1 per 100,000 population).[1]

Less than one percent (0.3%) of medical school students report they "hope to work" in Idaho after completing their medical training. [1]

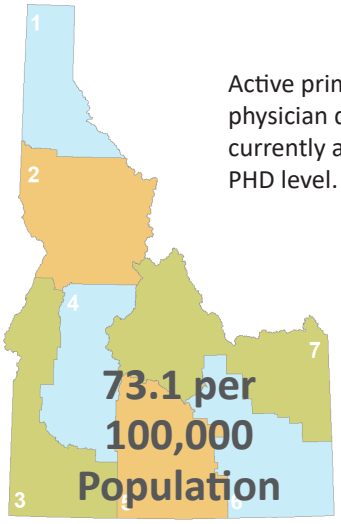
The percentage of Idaho land mass designated as a Health Professional Shortage Area (HPSA): [1]

Primary Care HPSA:	96%
Dental HPSA:	97%
Mental HPSA:	100%

How Many Primary Care Physicians?

1,231
Active primary care physicians in Idaho (2016)

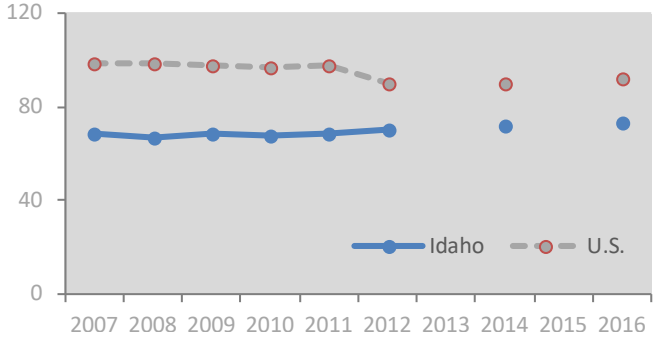
Where Are They?



Active primary care physician data are not currently available at the PHD level.

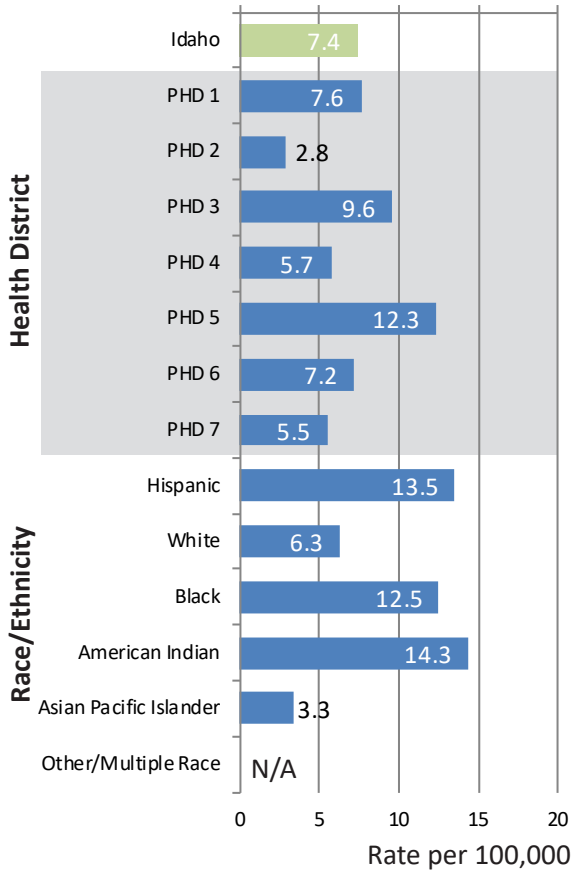
2007-2016

The rate of active primary care physicians (per 100,000) has remained unchanged since 2007. Idaho's active primary care physician rate has been significantly lower than the **U.S.** rate over the past 10 years. [1]

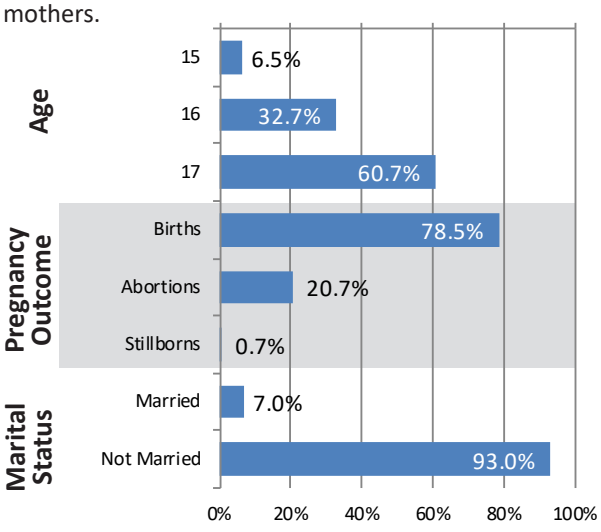


1. Association of American Medical Colleges. 2017 State Physician Workforce Data Book, 2017.

The rate (per 1,000 females) of teen pregnancy among Idaho females age 15-17 varies among race/ethnicity.[1]



The majority of teen pregnancies (age 15-17) are among 17 year old females (53%). Most teen pregnancies result in a live birth (81%) and more than three-fourths (87%) of births occur to unmarried teen mothers.



How Many Adolescent Females?

275

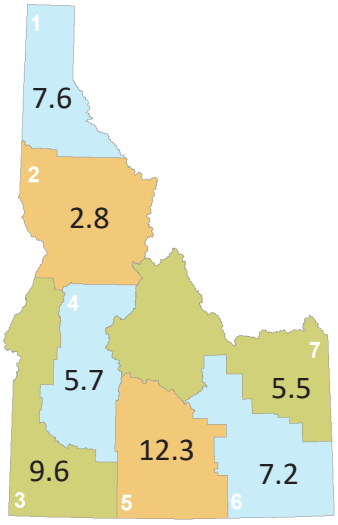
Idaho teens (age 15-17) became pregnant in 2017

Who Are They?

American Indian Teens

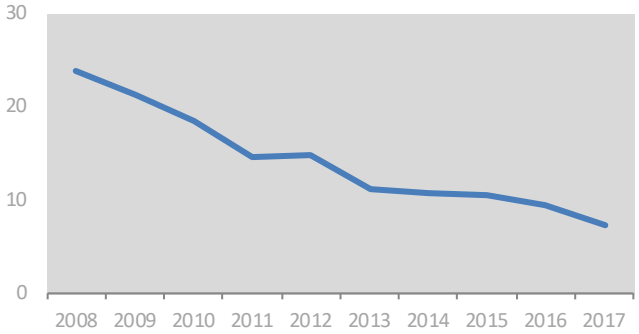
14 (per 1,000 females) vs. 6 (per 1,000 females) among White non-Hispanic female teens became pregnant (age 15-17)

Where Are They?



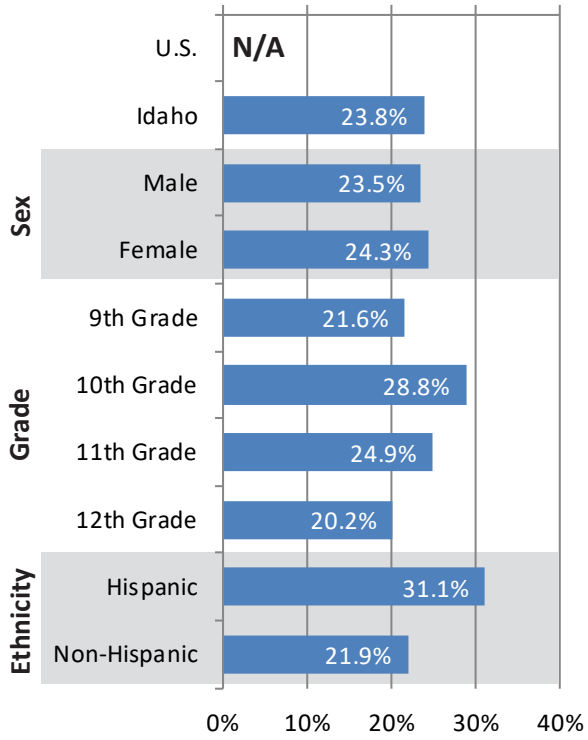
2008-2017

The teen pregnancy rate in **Idaho** decreased significantly between 2008 and 2017.[1]



1. Idaho Department of Health and Welfare, Division of Public Health, Bureau of Vital Records and Health Statistics. Special request - September, 2018.

The percentage of Idaho students who had sexual intercourse for the first time at age 15 or younger varies by grade level and Hispanic ethnicity.



How Many Adolescents?

21,400

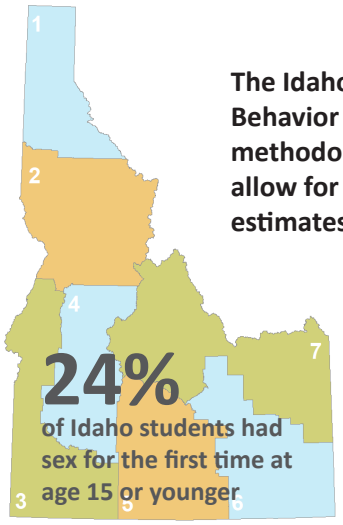
24% of Idaho adolescents (grades 9-12) had sexual intercourse for the first time at age 15 or younger

Who Are They?

Hispanics

31% vs. 22% among non-Hispanic students had sexual intercourse for the first time at age 15 or younger

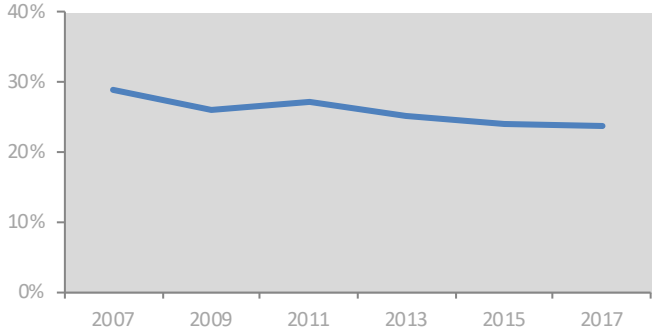
Where Are They?



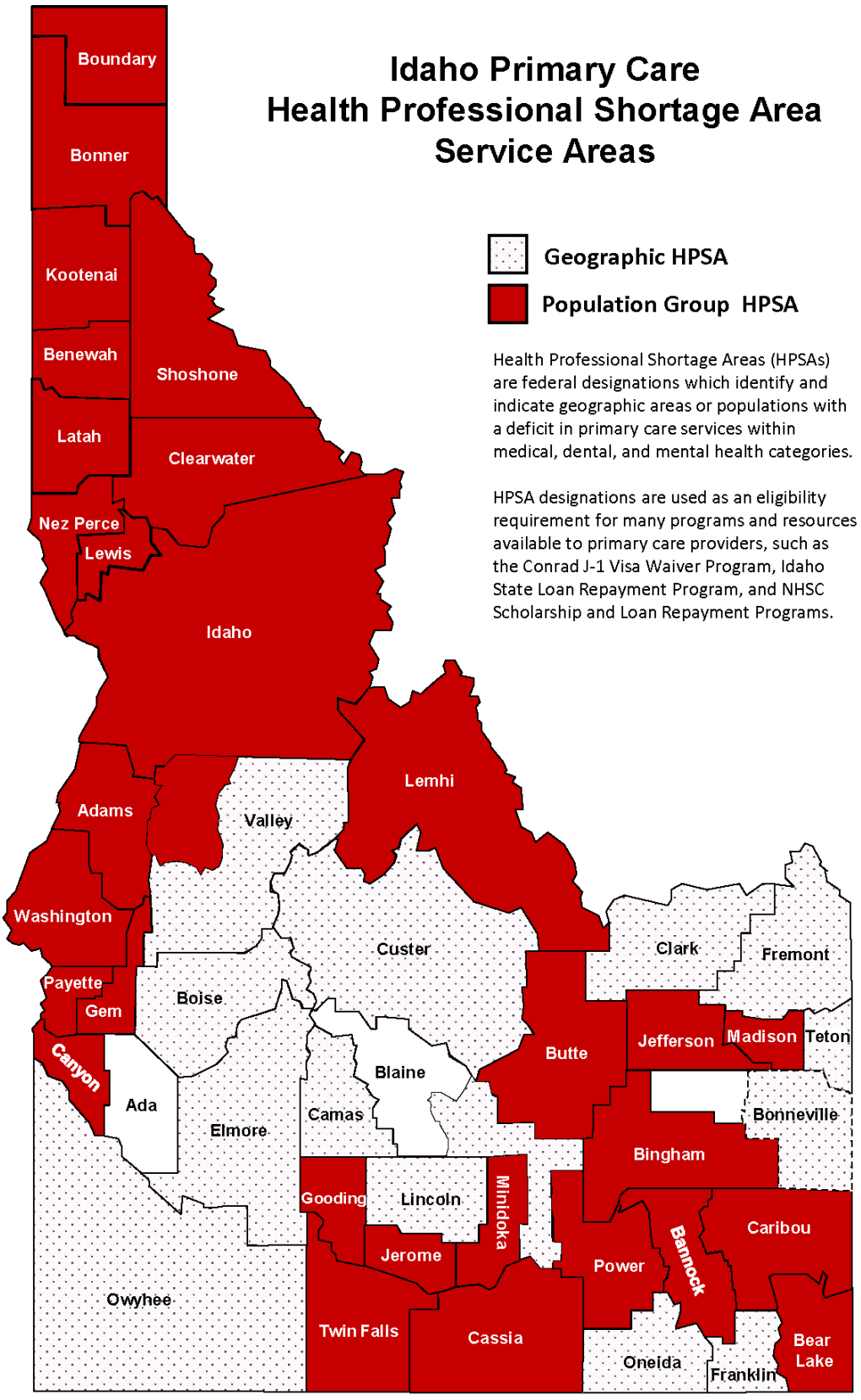
The Idaho Youth Risk Behavior Survey (YRBS) methodology does not allow for PHD-level estimates

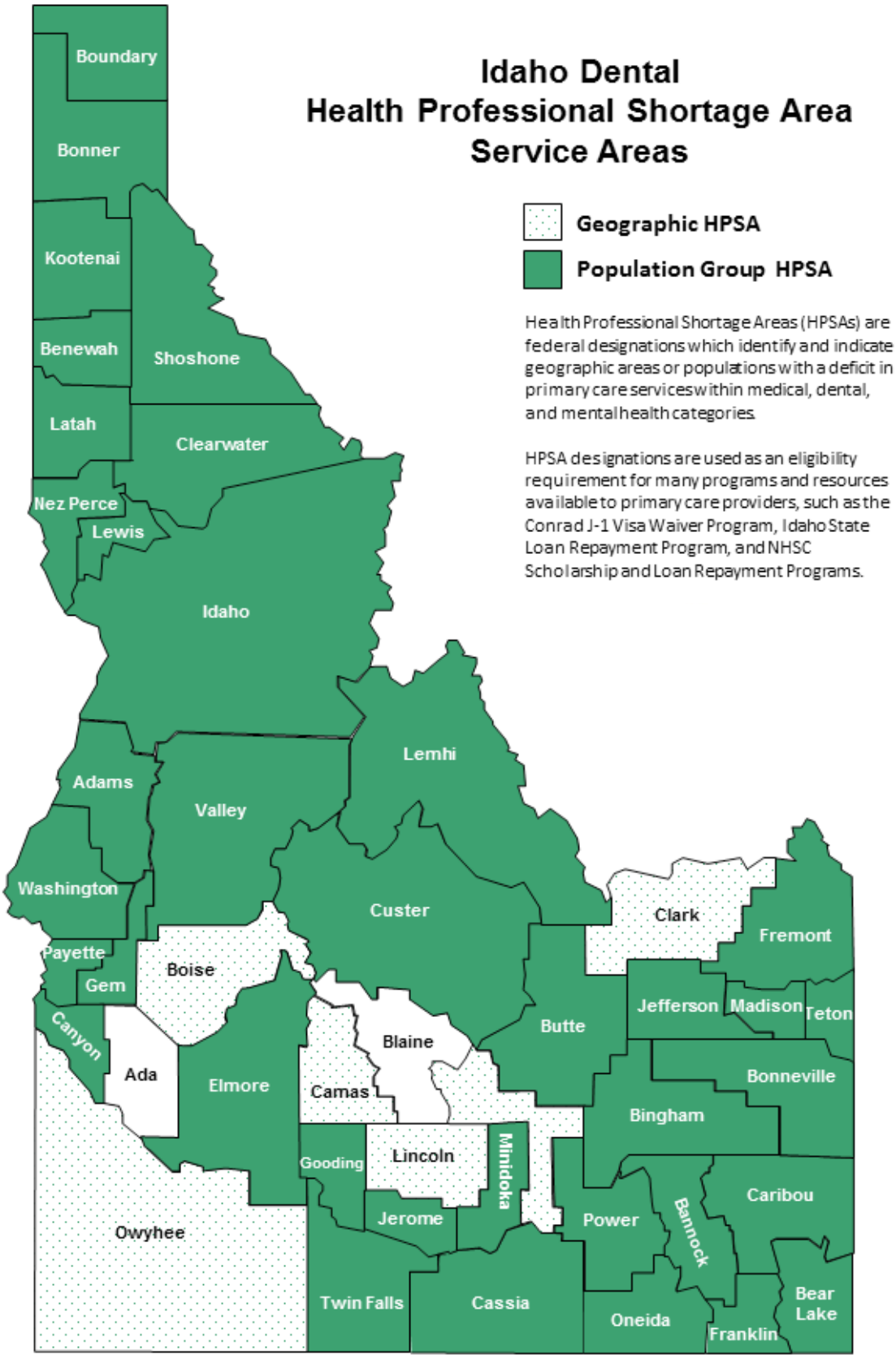
2007-2017

The percentage of adolescents in Idaho who had sexual intercourse for the first time at age 15 years or younger decreased slightly between 2007 and 2017.[1]



Source: *Idaho Youth Risk Behavior Survey: A Healthy Look at Idaho Youth*. Idaho State Department of Education, 2017.


Idaho Primary Care
Health Professional Shortage Area
Service Areas
Geographic HPSA
Population Group HPSA
Health Professional Shortage Areas (HPSAs) are federal designations which identify and indicate geographic areas or populations with a deficit in primary care services within medical, dental, and mental health categories.
HPSA designations are used as an eligibility requirement for many programs and resources available to primary care providers, such as the Conrad J-1 Visa Waiver Program, Idaho State Loan Repayment Program, and NHSC Scholarship and Loan Repayment Programs.
Boundary
Bonner
Kootenai
Benewah
Shoshone
Latah
Clearwater
Nez Perce
Lewis
Idaho
Lemhi
Adams
Valley
Washington
Custer
Clark
Fremont
Payette
Gem
Boise
Canyon
Ada
Elmore
Blaine
Camas
Butte
Jefferson
Madison
Teton
Bonneville
Bingham
Gooding
Lincoln
Minidoka
Jerome
Power
Bannock
Caribou
Owyhee
Twin Falls
Cassia
Oneida
Franklin
Bear Lake


Idaho Dental
Health Professional Shortage Area
Service Areas
Geographic HPSA
Population Group HPSA
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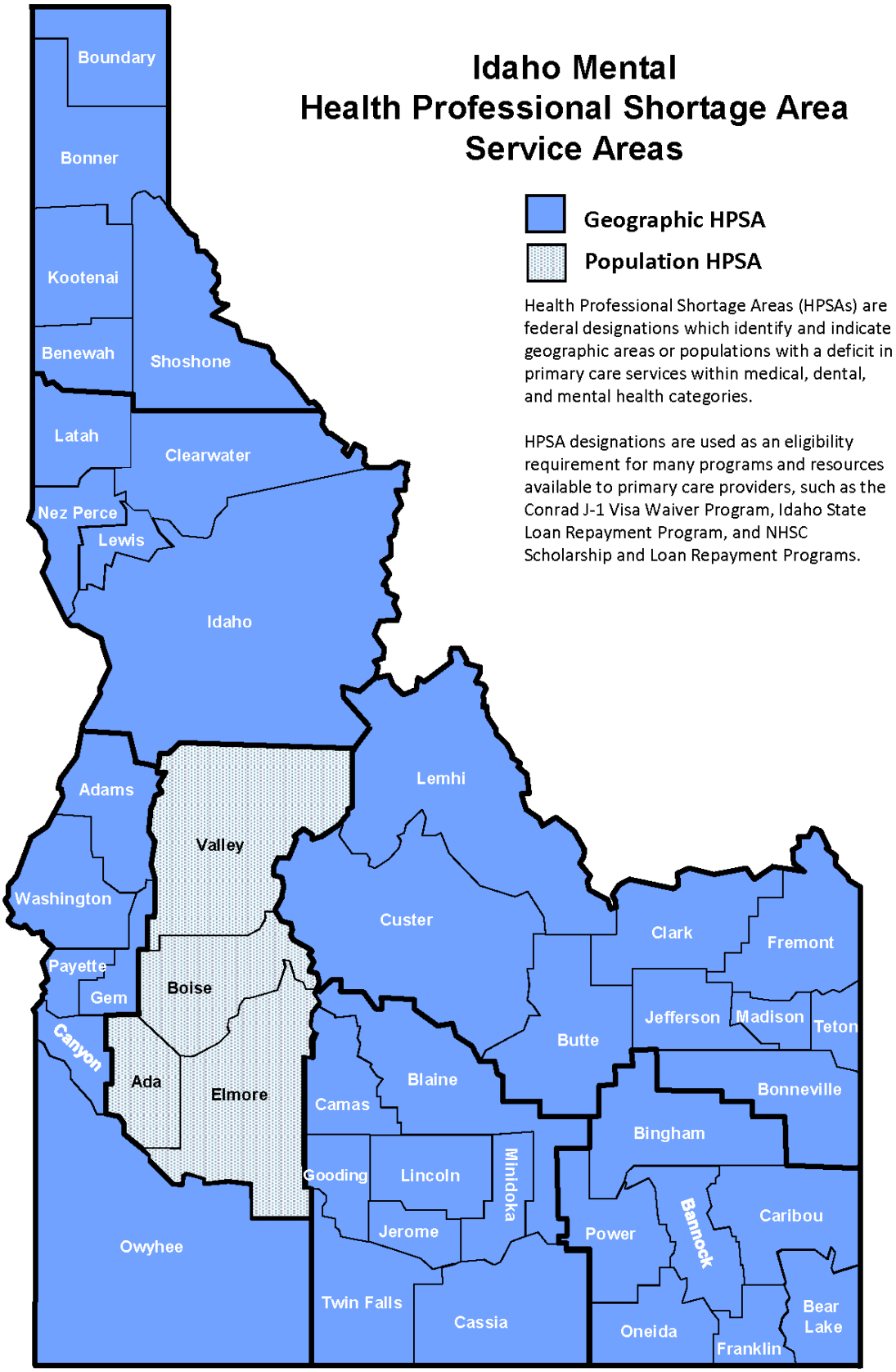
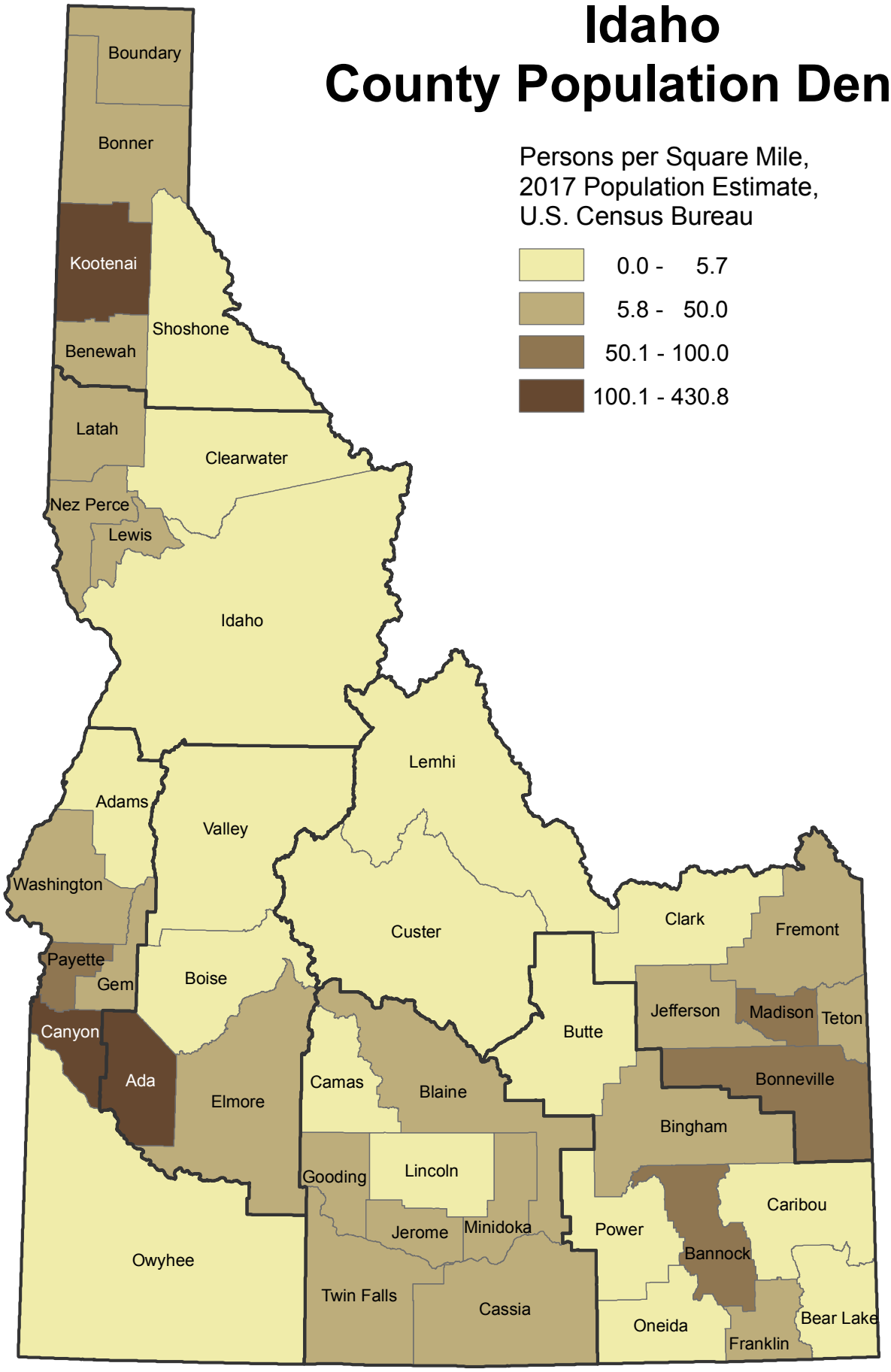
Oneida
Franklin
Bear Lake


Idaho Mental
Health Professional Shortage Area
Service Areas
Geographic HPSA
Population HPSA
Health Professional Shortage Areas (HPSAs) are federal designations which identify and indicate geographic areas or populations with a deficit in primary care services within medical, dental, and mental health categories.
HPSA designations are used as an eligibility requirement for many programs and resources available to primary care providers, such as the Conrad J-1 Visa Waiver Program, Idaho State Loan Repayment Program, and NHSC Scholarship and Loan Repayment Programs.
Boundary
Bonner
Kootenai
Benewah
Shoshone
Latah
Clearwater
Nez Perce
Lewis
Idaho
Adams
Valley
Lemhi
Washington
Custer
Clark
Fremont
Payette
Gem
Boise
Jefferson
Madison
Teton
Canyon
Ada
Elmore
Butte
Blaine
Bonneville
Camas
Bingham
Gooding
Lincoln
Minidoka
Caribou
Jerome
Power
Bannock
Owyhee
Twin Falls
Cassia
Oneida
Bear Lake
Franklin

Idaho
County Population Density



Progress Report for 2018 Strategies and Measures

Introduction:

This section is a status update on the measures selected for *Get Healthy Idaho: Measuring and Improving Population Health* (January, 2018). The health priorities selected were access to care, diabetes, tobacco, and obesity. Over the past year, work on these strategies crossed multiple bureaus and divisions within the Department of Health and Welfare and involved partnerships from outside of the Department. Progress towards reaching the target of each measure is reported in the "Actual" column on the following tables.

Health Priority: ACCESS TO CARE
Five Year Goal: Increase access to healthcare services
SMART Objective: Increase to 50, the number of PCMHs that adopt an element of the virtual PCMH by January 2019

CY = Calendar Year
SFY = State Fiscal Year

Strategy 1: Review and renew healthcare shortage areas to maximize funding and healthcare provider recruitment efforts in rural and frontier counties.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of currently designated areas reviewed annually as dental, mental, primary care Health Professional Shortage Areas	46 per year	46	88 (6/30/18)	Met
Strategy 2: Develop and implement virtual patient-centered medical homes (PCMH) through Community Health EMS (CHEMS), community health workers (CHWs), and Telehealth.				
Measure 1:	Baseline	Target	Actual	Met/Unmet
Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2 (CY2015)	13	17 (10/1/2018)	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of Idaho EMS agencies providing CHEMS services	1 (CY2015)	13	8 (10/1/2018)	Unmet
Measure 3:	Baseline	Target	Actual	Met/Unmet
Number of CHWs trained through Idaho State University program	0 (CY2015)	75	76 (6/30/2018)	Met
Measure 4:	Baseline	Target	Actual	Met/Unmet
Number of telehealth programs established in PCMHs	0 (CY2015)	12	12	Met
Strategy 3: Recruit new and existing PCMH's to participate in the SHIP.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of primary care clinics recruited to participate in the SHIP PCMH transformation	13 (CY2015)	55	165 (6/30/2018)	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of Regional Collaboratives	0 (CY2015)	7	7 (6/30/2018)	Met

Summary of the work completed to date:

Health Professional Shortage Areas (HPSAs) are federal designations that indicate healthcare provider shortages in primary care, dental health, and mental health. The DPH's Bureau of Rural Health and Primary Care is responsible for designating, updating and managing HPSAs in Idaho according to federal guidelines. In 2016, 93 areas in Idaho were designated as a HPSA. Currently, 48 areas qualify as medically underserved (MUA) or as having medically underserved populations (MUP).

In December 2017, 14 paramedics from 8 EMS agencies completed the community paramedic course at Idaho State University. During the past year, the bureau facilitated and conducted 7 learning collaborative webinars for Community Health EMS (CHEMS) agencies and Community Health Workers (CHW) on a variety of health topics. To further support

continuing education, CHEMS agencies participated in a full-day in-person event to receive best practices and national updates on CHEMS program development.

Training opportunities for CHWs expanded significantly during the year and 3 CHW courses were conducted by Idaho State University, including 2 live on-line courses and 1 in-person. A full-day learning event for CHWs is scheduled in July 2018.

Efforts to support the development and expansion of telehealth included a subgrant opportunity for SHIP PCMHs and CHEMS agencies. Twelve subgrants were successfully awarded to establish new telehealth programs to increase access to clinical services, including behavioral health, pediatric services, diabetes management, oncology, and school-based health services. Continuing education for these new telehealth sites was provided through 2 learning collaborative webinars and site visits from a technical assistance contractor.

To identify challenges and opportunities related to telehealth expansion in Idaho, the bureau planned and conducted a statewide telehealth strategic planning meeting. Over 40 telehealth stakeholders from across the state representing hospitals, urban and rural health clinics, health systems, Community Health EMS (CHEMS), government, insurance, telehealth consulting experts, associations, and academia participated. Participants reached consensus on the value and need for advancing telehealth services across Idaho.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase from 51 to 55 the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2018

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of ADA-recognized/AADE-accredited DSME programs	28 (SFY2015)	40	38	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of persons with diabetes who have at least one encounter at an ADA recognized or AADE accredited program.	6,412 (CY2012)	8,400	N/A*	Unmet
Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.				
Measure 1:	Baseline	Target	Actual	Met/Unmet
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	320	865	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of CDC-recognized or pending recognition DPPs	3 (SFY2015)	15	14	Unmet

*The data for this measure are no longer being collected and reported by CDC.

Summary of the work completed to date:

The Idaho Diabetes Prevention and Control Program (DPCP) has offered subgrant awards to health systems, ADA recognized/AADE accredited DSME, and CDC-recognized/pending recognition DPPs to increase the number of DSME and DPP programs available in Idaho. Increasing the number of programs available is the first step to increasing participant enrollment. Although enrollment numbers were not met for strategy 2, measure 1, the DPCP will continue to work Health Systems, DSMES/T, and DPPs to increase awareness, develop sustainable referral sources, and promote attendance to these programs.

Health Priority: TOBACCO
Five Year Goal: Reduce tobacco use in Idaho
SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 57.6% to 60.0% by July 2018

Strategy 1: Increase referrals to cessation services.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of women enrolled in Women's Health Check ages 21-64 referred to the QuitLine cessation services **Note**: Target is lower than baseline due to decreased enrollment for Women's Health Check services.	708 (SFY2014)	700	762	Met
Measure 2:	Baseline	Annual Target	Actual	Met/Unmet
Number of tobacco users who registered for Idaho QuitLine cessation services	8,142 (SFY2015)	8,956 (10% above baseline)	8,143	Unmet
Strategy 2: Promote the use of Nicotine Replacement Therapy (NRT) for appropriate individuals enrolled in cessation services.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of Idaho QuitLine registrants shipped at least 4 weeks of NRT	5,943 (SFY2015) (73% of total registrants)	6,717 (75% of target for phone and QuitLine)	6,017	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Proportion of registrants ordering NRT through Idaho QuitLine cessation services	73% (SFY2015)	75%	74%	Unmet

Summary of the work completed to date:

Project Filter developed and implemented a new campaign this year. Information gathered from target population focus groups, including pregnant mothers 18-24 years of age, informed the development of messages for the campaign. Project Filter has also been working with several universities to develop or strengthen comprehensive tobacco policies, having a direct effect on both males and females 18-24 years of age. These activities resulted in increased call volume and NRT orders for this age group.

The number of calls made to the Idaho QuitLine by those who are 18-24 years of age, is not a significantly large proportion. Project Filter plans to collect and report on these same measures for next year; however, will expand data collection and reporting to include all age ranges. This will provide better data and evaluation of outreach efforts to promote Idaho Quitline cessation services.

Project Filter also identified healthcare provider referrals as a point of emphasis for the Program. To more effectively promote provider referrals, Project Filter staff developed and began distributing a healthcare provider referral toolkit. To date, over 150 toolkits have been distributed by state staff and Public Health Districts to a variety of health clinics and systems around the state.

Health Priority: OBESITY
Five Year Goal: Reduce the burden of obesity in Idaho
SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 27.8% to 26.8% by December 2018

Strategy 1: Increase healthy options for infants and children through awareness, education, and collaboration.				
Measure 1: Number of childcare providers who have participated in Let's Move trainings	Baseline	3 Year Cumulative Target	Actual	Met/Unmet
	110 (SFY2015)	280	344	Met
Measure 2: Number of childcare providers that develop an action plan to improve nutrition	Baseline	3 Year Cumulative Target	Actual	Met/Unmet
	80 (SFY2015)	200	247	Met
Measure 3: Percentage of children on WIC age 2-5 who are overweight or obese	Baseline	Annual Target	Actual	Met/Unmet
	28.1% (SFY2016)	26%	17%	Unmet
Measure 4: Percentage of women on WIC who are still breastfeeding at 3 months	Baseline	Target	Actual	Met/Unmet
	53.6% (SFY2016)	55%	50.6%	Unmet
Measure 5: Percentage of 3rd grade students who are overweight or obese based on BMI	Baseline	Target	Actual	Met/Unmet
	29.7% (2011-12)	26%	28.6%	Unmet

Youth overweight and obesity is defined on pages 39 and 40
Adult overweight and obesity is defined on pages 41 and 42

Summary of the work completed to date:

Idaho Physical Activity and Nutrition (IPAN) Coordinators implemented 14 Let's Move! Child Care (LMCC) workshops in SFY16. Attendance numbers are decreasing as the provider population with interest in this subject becomes saturated. IPAN staff worked with IdahoSTARS to connect the Professional Development System of trainings to online Better Kid Care (BKC) trainings developed by Penn State Extension, specifically focusing on the five LMCC online modules BKC developed for providers. These trainings are being promoted by IdahoSTARS and IPAN coordinators as professional development opportunities for Idaho's providers. If all five modules are taken, a provider will receive 10 credits at a cost of only $25.

Moving forward, DPH IPAN staff and partners will develop a shortened version of the LMCC 2-day workshop format to be facilitated as a face-to-face, hands-on supplement to the online trainings. One set of workshops will be implemented by each local public health district in FY17 as they will also begin promoting the online training modules.

During FY17 and FY18, the local PHDs conducted 14 additional LMCC workshops. The workshops were condensed to 1-day with online modules offered to each provider for additional education on each of the five topic areas (nutrition, physical activity, screen time, healthy beverages, and breastfeeding support). The CDC funding for this initiative ended in June 2018. Over the five-year grant period the total number of childcare facilities trained on nutrition standards and guidelines was 344 (17 Spanish speaking) statewide. This includes larger centers, small centers, and in-home daycare. Of the facilities receiving training, 247 indicated nutrition as a place to make improvements and policy changes.

The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian (RD) to discuss weight/growth and healthy options going forward. During SFY18 WIC local agencies worked on objectives directly targeting decreasing the percentage of overweight and obese children in their agencies. RDs participated in monthly Nutrition Education Advisory Team (NEAT) conference calls. RD's and other key staff received related training by participating in various webinars and conferences throughout the year (including those sponsored by the National WIC Association).

During SFY18, WIC focused on increasing the nutrition education options available to participants (in addition to individual one-on-one appointments). Some local agencies added or expanded group classes, others increased what was offered at Quick WIC (nutrition fairs), and three local agencies piloted offering online nutrition education (WICSmart). These efforts aim to provide each WIC family with an easily accessible nutrition education option that will effectively meet their needs.

There was some discrepancy in data when the initial WIC targets were created.

All pregnant women participating in the WIC Program are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success. All local agencies worked on objectives directly focused on increasing breastfeeding initiation rates and/or breastfeeding duration rates. Breastfeeding related staff received training at the Idaho Breastfeeding Summit and The Center for Breastfeeding's Lactation Counselor Training Course in addition to regularly scheduled in-service trainings.

Introduction:

This section is an update on the status of strategies and measures selected for *Get Healthy Idaho: Measuring and Improving Population Health* (January, 2017). The health priorities selected were access to care, diabetes, tobacco, and obesity. Over the past year and a half, work on these strategies crossed multiple bureaus and divisions within the Department of Health and Welfare and involved partnerships from outside of the Department. Progress towards reaching the target of each measure is reported in the "Actual" column on the following tables.

Health Priority: ACCESS TO CARE
Five Year Goal: Increase access to healthcare services
SMART Objective: Initiate three efforts to identify or address barriers facing Idaho's underserved areas and populations by December 2016

CY = Calendar Year
SFY = State Fiscal Year

Strategy 1: Review and renew healthcare shortage areas to maximize funding and healthcare provider recruitment efforts in rural and frontier counties.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of currently designated areas reviewed annually as dental, mental, primary care Health Professional Shortage Areas	46 per year	46	58	Met
Strategy 2: Develop and implement virtual patient-centered medical homes (PCMH) through Community Health EMS (CHEMS), community health workers (CHWs), and Telehealth.				
Measure 1:	Baseline	Target	Actual	Met/Unmet
Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2 (CY2015)	13	9 (6/30/2017)	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of Idaho EMS agencies providing CHEMS services	1 (CY2015)	13	4 (6/30/2017)	Unmet
Measure 3:	Baseline	Target	Actual	Met/Unmet
Number of CHWs trained through Idaho State University program	0 (CY2015)	75	34 (6/30/2017)	Unmet
Measure 4:	Baseline	Target	Actual	Met/Unmet
Number of telehealth programs established in PCMHs	0 (CY2015)	12	3	Unmet
Strategy 3: Recruit new and existing PCMH's to participate in the SHIP.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of primary care clinics recruited to participate in the SHIP PCMH transformation	13 (CY2015)	55	110 (6/30/2017)	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of RCs	0 (CY2015)	7	7 (6/30/2017)	Met

Summary of the work completed to date:

Health Professional Shortage Areas (HPSAs) are federal designations that indicate healthcare provider shortages in primary care, dental health, and mental health. The DPH's Bureau of Rural Health and Primary Care is responsible for designating, updating and managing HPSAs in Idaho according to federal guidelines. In 2016, 93 areas in Idaho were designated as a HPSA. Currently, 47 areas qualify as medically underserved (MUA) or as having medically underserved populations (MUP).

Seven local Emergency Medical Services (EMS) agencies sent a total of 13 students to CHEMS training in year two (2017). There are 12 students signed up for the third year from seven EMS agencies. The College of Western Idaho will be administering a Community Health EMS course for Emergency Medical Technicians (EMTs) and Advanced EMTs. There

are 20 students (from seven EMS agencies) who are interested in attending the program in 2018. Continuing education opportunities for CHEMS providers have consisted of two topical webinars with a third planned for early 2018. Planning is also underway for the first CHEMS Learning Collaborative. Boise State University and the Area Agency on Aging, under contract with the Bureau of EMS & Preparedness, developed the framework for a pilot study to test the delivery and sustainability of CHEMS in a rural community in Idaho.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase by 10% the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2016

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education and Support/Training (DSMES/T) Programs.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of ADA-recognized/AADE-accredited DSME programs	28 (SFY2015)	40	36	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of persons with diabetes who have at least one encounter at an ADA recognized or AADE accredited program.	6,412 (CY2012)	8,400	7,994	Unmet
Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.				
Measure 1:	Baseline	Target	Actual	Met/Unmet
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	320	605	Met
Measure 2:	Baseline	Target	Actual	Met/Unmet
Number of CDC-recognized or pending recognition DPPs	3 (SFY2015)	15	16	Met

Summary of the work completed to date:

The Idaho Diabetes Program has offered subgrant awards to health systems and ADA recognized/AADE accredited DSME programs to help increase the number of DSME and DPP programs available in Idaho. The increase in access to these programs is the first step to increasing participant enrollment. Although enrollment numbers were not met for strategy 2, measure 1, the Idaho Diabetes Program has developed and is beginning implementation of a social marketing plan for both DSME and DPP to increase awareness and promote attendance to these programs.

Health Priority: TOBACCO
Five Year Goal: Reduce tobacco use in Idaho
SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 61.3% to 66.3% by July 2016

Strategy 1: Increase referrals to cessation services.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of women enrolled in Women's Health Check ages 21-64 referred to the QuitLine cessation services **Note**: Target is lower than baseline due to decreased enrollment for Women's Health Check services.	708 (SFY2014)	700	1,049	Met
Measure 2:	Baseline	Annual Target	Actual	Met/Unmet
Number of tobacco users who registered for Idaho QuitLine cessation services	8,142 (SFY2015)	8,956 (10% above baseline)	8,081	Unmet
Strategy 2: Promote the use of Nicotine Replacement Therapy (NRT) for appropriate individuals enrolled in cessation services.				
Measure 1:	Baseline	Annual Target	Actual	Met/Unmet
Number of Idaho QuitLine registrants shipped at least 4 weeks of NRT	5,943 (SFY2015) (73% of total registrants)	6,717 (75% of target for phone and QuitLine)	5,741	Unmet
Measure 2:	Baseline	Target	Actual	Met/Unmet
Proportion of registrants ordering NRT through Idaho QuitLine cessation services	73% (SFY2015)	75%	71%	Unmet

Summary of the work completed to date:

Project Filter developed and implemented a new campaign this year, taking into account feedback from a focus group on target populations prevalent in Idaho. One of the campaign focuses was designed to reach pregnant mothers in the 18-24 age range. Project Filter has also been working with several universities in an effort to develop or strengthen tobacco policies, having a direct effect on male and female 18-24 year olds. The outcomes resulting from these efforts are increased call volume and NRT orders for the targeted age group.

Overall, 18-24 year olds are not a large proportion of callers to the Idaho QuitLine. Project Filter plans to collect and report on these same measures for next year, but expand reporting for the entire population rather than only 18-24 year olds. This will provide a better view of the effect outreach has on all tobacco users in Idaho.

Health Priority: OBESITY
Five Year Goal: Reduce the burden of obesity in Idaho
SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 27.8% to 26.8% by December 2017

Strategy 1: Increase healthy options for infants and children through awareness, education, and collaboration.				
Measure 1: Number of childcare providers who have participated in Let's Move trainings	Baseline	3 Year Cumulative Target	Actual	Met/Unmet
	110 (SFY2015)	280	172	Unmet
Measure 2: Number of childcare providers that develop an action plan to improve nutrition	Baseline	3 Year Cumulative Target	Actual	Met/Unmet
	80 (SFY2015)	200	130	Unmet
Measure 3: Percentage of children on WIC age 2-5 who are overweight or obese	Baseline	Annual Target	Actual	Met/Unmet
	28.1% (SFY2016)	26%	17%	Unmet
Measure 4: Percentage of women on WIC who are still breastfeeding at 3 months	Baseline	Target	Actual	Met/Unmet
	53.6% (SFY2016)	55%	50.6%	Unmet
Measure 5: Percentage of 3rd grade students who are overweight or obese based on BMI	Baseline	Target	Actual	Met/Unmet
	29.7% (2011-12)	26%	28.6%	Unmet

Youth overweight and obesity is defined on pages 39 and 40
Adult overweight and obesity is defined on pages 41 and 42

Summary of the work completed to date:

Idaho Physical Activity and Nutrition (IPAN) Coordinators implemented 14 Let's Move! Child Care (LMCC) workshops in SFY16. Attendance numbers are decreasing as the provider population with interest in this subject becomes saturated. IPAN staff worked with IdahoSTARS to connect the Professional Development System of trainings to online Better Kid Care (BKC) trainings developed by Penn State Extension, specifically focusing on the five LMCC online modules BKC developed for providers. These trainings are being promoted by IdahoSTARS and IPAN coordinators as professional development opportunities for Idaho's providers. If all five modules are taken, a provider will receive 10 credits at a cost of only $25.

Moving forward, DPH IPAN staff and partners will develop a shortened version of the LMCC 2-day workshop format to be facilitated as a face-to-face, hands-on supplement to the online trainings. One set of workshops will be implemented by each local public health district in FY17 as they will also begin promoting the online training modules.

The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian to discuss weight and healthy options going forward. There was some discrepancy in data when the initial targets were developed. All pregnant women participating in the WIC program are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success.

Introduction:
This section is an update on the status of strategies and measures selected for *Get Healthy Idaho: Measuring and Improving Population Health* (July, 2016). The health priorities selected were access to care, diabetes, tobacco, and obesity. Over the past year and a half, work on these strategies crossed multiple bureaus and divisions within the Department of Health and Welfare and involved partnerships from outside of the Department.

Health Priority: ACCESS TO CARE
Five Year Goal: Increase access to healthcare services
SMART Objective: Initiate three efforts to identify or address barriers facing Idaho's underserved areas and populations by December 2016

CY = Calendar Year
SFY = State Fiscal Year

Strategy 1: Review and renew healthcare shortage areas.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of designated areas qualifying as dental, mental, primary care Health Professional Shortage Areas	0 (CY2015)	70	93	Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of designated areas qualifying as Medically Underserved Areas	0 (CY2015)	54	53	Met
Strategy 2: Develop and implement Community Health Emergency Medical Services (CHEMS) programs.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of Idaho EMS agencies recruited to participate in the CHEMS initiative	2 (CY2015)	3	4	Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of paramedics receiving formal CHEMS trainings	0 (CY2015)	12	9	Not Met
Strategy 3: Recruit new and existing primary care medical homes (PCMH) to participate in the SHIP.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of primary care clinics recruited to participate in the State Healthcare Innovation Plan PCMH transformation	13 (CY2015)	55	55	Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of Regional Health Collaboratives established	0 (CY2015)	7	7	Met

Summary of the work completed to date:

Three types of Health Professional Shortage Areas (HPSA) are measured in Idaho: primary care, dental, and mental health. Medical doctors in a primary care shortage area provide direct patient and outpatient care in one of the following primary care specialties: general or family practice, general internal medicine, pediatrics, obstetrics and gynecology. The bureau uses federal guidelines to establish Idaho's HPSA designations. In 2015, 93 areas in Idaho were designated given a HPSA designation. In 2015, 53 areas qualified as medically underserved areas (MUA). Thirty of Idaho's 44 counties were reviewed during the year, with one being newly designated and two counties moving from partial designation to full designation.

Two local Emergency Medical Services (EMS) agencies have committed to sending students, five in total, to CHEMS training in year one. Recruitment of agencies to participate in the CHEMS program is ongoing. The initiation of a CHEMS training course for agency administrators has had a positive effect on recruitment.

All local Public Health Districts successfully organized and launched a Regional Health Collaborative in their district.

Health Priority: DIABETES

Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

SMART Objective: Increase by 10% the availability of educational opportunities for Idahoans to manage modifiable risk factors associated with diabetes or pre-diabetes by July 2016

Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of ADA-recognized/AADE-accredited DSME programs	28 (SFY2015)	33	36	Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of CDC-recognized DPPs	3 (SFY2015)	9	13	Met
Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self-Management Education Programs.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of persons with pre-diabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized DPP	89 (SFY2014)	300	138	Not Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of persons with diabetes how have at least one encounter at an ADA/AADE DSME Program	6,534	8,000	8,050	Met

Summary of the work completed to date:

The Idaho Diabetes Program has offered subgrant awards to health systems and ADA recognized/AADE accredited DSME programs to help increase the number of DSME and DPP programs available in Idaho. The increase in access to these programs is the first step to increasing participant enrollment. Although enrollment numbers were not met for strategy 2, measure 1, the Idaho Diabetes Program has developed and is beginning implementation of a social marketing plan for both DSME and DPP to increase awareness and promote attendance to these programs.

Health Priority: TOBACCO
Five Year Goal: Reduce tobacco use in Idaho
SMART Objective: Increase the percentage of Idaho adult smokers that have attempted to quit smoking in the past 12 months from 61.3% to 66.3% by July 2016

Strategy 1: Increase referrals to cessation services.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of women 21-64 years of age referred for QuitLine/QuitNet cessation classes	708 (SFY2014)	825	673	Not Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of 18-24 year olds who registered for QuitLine/QuitNet cessation services (1-call, multi-call, online)	852 (SFY2015)	895	1,173	Met
Strategy 2: Promote the use of nicotine replacement therapy (NRT) for appropriate individuals enrolled in cessation services.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of 18-24 year olds that were shipped 8 weeks of Nicotine Replacement Therapy	281 (SFY2015)	295	801	Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Proportion of registrants ordering Nicotine Replacement Therapy the Idaho QuitLine/ QuitNet	73% (SFY2015)	75%	91%	Met

Summary of the work completed to date:

Project Filter developed and implemented a new campaign this year, taking into account feedback from a focus group on target populations prevalent in Idaho. One of the campaign focuses was designed to reach pregnant mothers in the 18-24 age range. Project Filter has also been working with several universities in an effort to develop or strengthen tobacco policies, having a direct effect on male and female 18-24 year olds. The outcomes resulting from these efforts are increased call volume and NRT orders for the targeted age group.

Overall, 18-24 year olds are not a large proportion of callers to the Idaho QuitLine. Project Filter plans to collect and report on these same measures for next year, but expand reporting for the entire population rather than only 18-24 year olds. This will provide a better view of the effect outreach has on all tobacco users in Idaho.

Health Priority: OBESITY
Five Year Goal: Reduce the burden of obesity in Idaho
SMART Objective(s): Decrease the percentage of children age 10-17 who are overweight or obese from 27.8% to 26.8% by December 2017

Strategy 1: Increase healthy options for infants and children through education and collaboration.				
Measure 1:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Number of childcare providers who have attended Let's Move! Child Care trainings	170	280	152	Not Met
Measure 2:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Percentage of children on WIC age 2-5 who are obese	7%	6%	11.9%	Not Met
Measure 3:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Percentage of children on WIC age 2-5 who are overweight	9%	8%	16.2%	Not Met
Measure 4:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Percentage of women on WIC who initiated breastfeeding at birth	86% (SFY2013)	90%	86.7%	Not Met
Measure 5:	**Baseline**	**Target**	**Actual**	**Met/Not Met**
Percentage of women on WIC who are still breastfeeding at 3 months	52% (SFY2013)	55%	53.6%	Not Met
Strategy 1, Measure 2 and Measure 3: The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian to discuss weight and healthy options going forward. There was some discrepancy in data when the initial targets were created.				
Strategy 1, Measure 4 and Measure 5: All pregnant women on WIC are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success.				

Youth overweight and obesity is defined on pages 35 and 36
Adult overweight and obesity is defined on pages 37 and 38

Summary of the work completed to date:

Idaho Physical Activity and Nutrition (IPAN) Coordinators implemented 14 Let's Move! Child Care (LMCC) workshops in SFY16. Attendance numbers are decreasing as the provider population with interest in this subject becomes saturated. IPAN staff worked with IdahoSTARS to connect the Professional Development System of trainings to online Better Kid Care (BKC) trainings developed by Penn State Extension, specifically focusing on the five LMCC online modules BKC developed for providers. These trainings are being promoted by IdahoSTARS and IPAN coordinators as professional development opportunities for Idaho's providers. If all five modules are taken, a provider will receive 10 credits at a cost of only $25.

Moving forward, IPAN staff and partners will develop a shortened version of the LMCC 2-day workshop format to be facilitated as a face-to-face, hands-on supplement to the online trainings. One set of workshops will be implemented by each local public health district in FY17 as they will also begin promoting the online training modules.

The caregivers of all WIC participants who are assigned a nutrition risk code for overweight or obesity are scheduled to meet with a registered dietitian to discuss weight and healthy options going forward. There was some discrepancy in data when the initial targets were created. All pregnant women participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program are made aware of the benefits of breastfeeding and the peer counseling support offered by the clinics. Peer Counselors are assigned postpartum WIC participants and engage in regular follow-up and coaching for breastfeeding success.

Population Health Assessment Summaries

Results are presented below by topic and contain responses categorized by area of the state served (i.e., Statewide vs. Public Health District). Because some of the organizations and agencies who responded to the health assessment survey work across multiple public health district boundaries their contributions to the health assessment are listed at the top of the table under "Statewide." The following priority health issues were highest among all of the responses (highest priority listed at the top with number of references in 2015, 2016, 2017, and 2018 combined):

- Obesity (17)
- Diabetes (16)
- Mental Health/Behavioral Health (15)
- Tobacco Use (15)
- Suicide (13)
- Physical Activity (13)
- Nutrition/Food Insecurity (11)
- Cardiovascular Health (11)
- Access to Care/Uninsured (11)
- Substance Abuse (11)

Those responses with an asterisk (*) in the following tables denote those 2016 and 2017 survey responses from organizations or agencies which have not ever conducted a health assessment or have not conducted a health assessment within the previous 5 years.

Population Health Assessment Results

What are the priority health issues for your organization or agency? (examples: drug abuse, tobacco use, diabetes, sedentary lifestyle)

Statewide
(2018)
1. *Dental Health.
2. *Tobacco use, lung disease prevention, lung disease management, clean air initiatives (to improve lung health).
3. *Addressing issues that lead to optimal oral health for Idahoans; current key initiative is leading efforts to integrate oral health into primary care settings across the state.

(2017)
1. Tobacco use, obesity, drug abuse, mental healthcare, workforce.
2. * Increased management of chronic conditions, which includes low back pain, diabetes, heart disease, opioid issues/ pain management, as well as driving greater focus on prevention and wellness initiatives with our employer clients and members.
3. * Heart Disease and Stroke, and all contributing factors (tobacco, obesity, nutrition, physical activity, sedentary lifestyle, systems of care, access to health care, etc).

(2016)
1. Oral cancer Screenings; tobacco use; rate of cavities; emergency care and drug abuse.
2. * Heart disease and stroke/cerebrovascular and related contributors including tobacco use; access to care; healthy eating options and marketing; active living (PE, Safe Routes to School, Complete Streets); systems of care (facility capabilities, data registries).
3. * Diabetes; weight management; exercise; nutrition services (including medical nutrition therapy); healthy diet.
4. * Preventing lung disease and supporting those with lung disease: tobacco prevention and cessation; education and resources for those with asthma; COPD; lung cancer; and other lung disease; advocacy for smoke-free air and other air quality issues.
5. * Opioid abuse; mental health and suicide prevention; tobacco prevention; obesity; and diabetes.
6. * Food insecurity.

Public Health District 1
(2018)
1. Mental Health/suicide, Substance abuse, and access to care.

(2017)
1. We are currently in the middle of conducting our CHA and have yet to analyze the results.

(2016)
1. Obesity; diabetes; mental Health; and suicide prevention.

(2015)
Substance abuse; illicit drug use; diabetes; mental health; tobacco use; obesity; suicide; physical inactivity; teen pregnancy and teen birth rate; cancer related mortality; child neglect and abuse.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2016)
1. Overweight/obesity/diabetes; access to health insurance; and behavioral health.
2. * Drug abuse; diabetes; sedentary lifestyle; and obesity.

(2015)
Mental health; suicide; alcohol abuse; drug abuse; affordability of healthcare; access to healthcare; physician shortage; lack of dentists; obesity; overweight; lack of child health and prevention resources; physical activity; nutrition; tobacco use and primary prevention/cessation; teen pregnancy; cancer; diabetes; diabetes care and management; smoking; heart disease and stroke.

Public Health District 3
(2018)
1. Behavioral health, prenatal health, senior health, oral health, diabetes, and senior health.

(2017)
1. Diabetes; behavioral health issues and hypertension.
2. Behavioral health; maternal and infant health; diabetes; oral health; senior health.

(2016)
1. Diabetes; hypertension; obesity; Social determinants of Health
2. Selected measures include: prenatal care, food insecurity, # of support providers (community health workers, CHEMS, peer support, etc.), oral health, obesity, and immunizations Top six in social determinants and health issues are listed below: Food insecurity, uninsured adults, prenatal care, early childhood ed., number of providers, poverty, immunizations, obesity and overweight, tobacco use, unintended pregnancy, diabetes, oral health.

(2015)
Obesity; high cholesterol; diabetes; poor nutrition habits; asthma; tobacco use; sexually transmitted infections (STIs); adult physical inactivity; teen births; high blood pressure; binge drinking; unsafe sex; mental illness; chronic disease; cancer; lung cancer; female breast cancer; prostate cancer; colon cancer; motor vehicle crashes; higher cost of healthy food options; fruit and vegetable consumption; physical inactivity; prenatal care; lack of health insurance coverage; lack of medical home; high cost of oral health; hypertension; cholesterol; mental health; suicide.

Public Health District 4
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 4 exclusively.

(2017)
1. Obesity, Mental Illness and substance abuse (we combine them as one need since they are so intertwined); Access; Tobacco Prevention and Cessation (with greater priority to prevention).
2. Obesity; diabetes; mental health/suicide; health insurance.
3. Lack of after-school programming preventing childhood obesity and increases access to nutrition and physical activity; Tobacco use; Lack of mental health resources.

(2016)
1. Obesity and related health issues; Mental health and substance abuse; Access for affordable care; Tobacco use.
2. *Tobacco use; nutrition; physical activity.

(2015)
Alcohol use and abuse; binge drinking; substance abuse; illicit drug use; vehicle crashes; accidents; diabetes; mental health; safe sex education; tobacco use; tobacco prevention; weight management; obesity; wellness/prevention; high cholesterol; skin cancer; suicide physical inactivity; hypertension; nutrition; low fruit and vegetable consumption; asthma; skin cancer; high teen birth rate; sexually transmitted infections; senior services; high percentage of the population reporting fair or poor general health; healthcare access including mental health; lack of health insurance coverage; lack of medical home; lack of healthy safe and nurturing relationships; high cost of oral health; lack of access to health food; lack of prenatal care.

Public Health District 5
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2017)
N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2016)
1. Overweight/Obesity; Cancers Pregnancy Prevention; BH and Suicide.

(2015)
Affordable care; affordable health insurance; availability of behavioral health services; more providers accepting public health insurance; screening programs; chronic disease management (diabetes); screening programs (mammography); chronic disease; access to healthcare for low income populations; access to behavioral health services for low income populations; shortage of specialists; primary care providers; children and family services; education support and assistance programs; homeless services; teen pregnancy/children in poverty; substance abuse services and programs; weight management; wellness/prevention; exercise programs/education; safe-sex education programs; tobacco cessation programs; access to public transportation; physical inactivity; services for aging population; ambulance response times; weekend pharmacy/lack of pharmacy; dental care; exercise programs/education (adult physical activity); nutrition education (teen nutrition); safe-sex education programs (STIs, teen birth rate); substance abuse services and programs; wellness and prevention (breast cancer, high cholesterol, lung cancer, respiratory disease, suicide).

Public Health District 6
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 6 exclusively.

(2017)
1. Heart disease; Diabetes; Tobacco Use; Suicide.
2. * Smoking; sedentary lifestyle; obesity; transitions of care; HIV infection.

(2016)
1. Heart disease; diabetes; suicide; Rx Drug abuse.
2. Heart Disease; Diabetes; Suicide.
3. Diabetes; tobacco use; obesity in adults and children; heart disease; suicide.
4. * Diabetes/obesity and substance use.

(2015)
Low-cost services; outreach for patients who do not access preventive care; communication with the community to address negative perceptions; continued emphasis on patient satisfaction; follow-up with patients who have been referred to other providers for care; accident prevention; suicide prevention; increase physical activity levels; increase prenatal care access and education; increase availability of health resources in Spanish; increase preventive screening rates; increase public awareness of existing resources.

Public Health District 7
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 7 exclusively.

(2017)
1. * Tobacco use; Substance Abuse; Obesity (child and adult); Food Safety; Lack of affordable health care (including dental health); Behavioral Health, including suicide; Immunization Rates; Increase in STD rates; Low cancer screen rates (colon, breast, etc.); Diabetes; Breastfeeding rates; Food insecurity.

(2016)
1. Child & Adult Immunizations; Tobacco/E-cigarette use by minors; Drug Abuse; behavioral health/Suicide; lack of affordable healthcare; lack of access to services (medical and dental); high poverty rates.

(2015)
Affordability of health services; mental health/suicide; alcohol abuse/substance abuse; palliative care and hospice; accidents; prevention/wellness; compliance behavior; Alzheimer's; cancer; stroke; lack of availability/access to mental health sercic3es; affordability of healthcare services; obesity and the need for a prevention/wellness resource center; addiction (alcohol and substance abuse); sever and persistent mentally ill conditions; lack of insurance; sexual assault; cancer services.

Based on the results of your most recent CHA, what (if any) are your most positive population measures (i.e., what is working)? (examples: low obesity rates, low poverty rates, high immunization rates)

Statewide
(2018)
1. *More children getting to the dentist, lower decay rates, lowering urgent need rates, increasing the number of sealants placed on children, seniors accessing dental services.
2. *Low rates of tobacco use; low rates of asthma, COPD, and lung cancer compared to other states.
3. *We rely on data from the Idaho Oral Health Program and national partners to identify target populations as appropriate for our efforts.

(2017)
1. * Through our Total Cost of Care program we see improved management of chronic conditions, appropriate use of pharmaceuticals, and increased engagement in preventive care. Additionally, we see some pockets of reduced avoidable ER usage (urgent care as alternative).
2. * Reduced access to tobacco; increased opportunity for physical exercise; improved nutrition options in public places.

(2016)
1. Sealants on kids.
2. * We are working on collecting more data for RDNs. Data collection is scattered. RDNs in hospitals may have data. RDNs in private practice and SHIP clinics are working together to collect data.
3. * Youth tobacco prevention programming is successful.
4. * Decrease in the number of food insecure Idahoans.

Public Health District 1
(2018)
N/A - no response

(2017)
N/A - no response.

(2016)
1. Obesity; diabetes; mental health; suicide prevention.

(2015)
Low crime; good jobs and healthy economy; access to healthcare.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - no response.

(2016)
1. Overweight/Obesity/Diabetes; access to health insurance; behavioral health.
2. * Our pain prescriptions have decreased as a result of our Controlled Substance Committee's diligent work.

(2015)
Low cancer; heart disease; diabetes; and flu/pneumonia mortality rates; moderately good environmental quality driven by low air pollution; low crime; good jobs and healthy economy; access to healthcare.

Public Health District 3
(2018)
1. Less reported binge drinking and drug use than the state average, low crime rates compared to national averages, lower breast cancer rates.

(2017)
1. Lower whooping cough rates.
2. Dental sealants for high risk children; Weight assessment and counseling for children and adolescents.

(2016)
1. High hypertension control.
2. Adults getting annual A1C; alcohol use in teens; binge drinking rates; heavy drinking rates.

(2015)
Years of Potential Life Lost (YPLL) is significantly lower than the national average; Low birth weight is below the national average; Supplemental Nutrition Assistance Program (SNAP); cash public assistance; active health resource guide; Preschool through college (P-16) coalition; suicide prevention efforts; Treasure Valley Education Partnership (TVEP); Bank On Treasure Valley; 2-1-1 Idaho Careline.

Public Health District 4

(2018)

N/A - there were no responses from organizations or agencies who serve Public Health District 4 exclusively.

(2017)

1. Valley County is in the top ten percent nationally (based on Robert Wood Johnson County Health Rankings) in 1) length of life, 2) smoking rates, 3) number of physicians per population, 4) preventable hospital stays, 5) obesity rates; interesting to note that Valley County Idaho is #1 nationally our of 3,100 counties for length of life in 2017; we were second nationally in 2016: again based on RWJF.
2. Health-focused agencies have the most policy, systems, and environmental supports; One school district had strong policy and environmental supports for nutrition and physical activity.

(2016)

1. Longevity; aggregate positive health behaviors; high number of local primary care providers.

(2015)

Availability of outdoor recreation; access to healthy foods; good air quality; low levels of violence and abuse; veterans services; prenatal care programs; community exercise programs; Years of Potential Life Lost lower than national average; low level of low birth weight; SNAP; CASH public assistance; P-16 Project; suicide prevention efforts; Treasure Valley Education Partnership; Bank On Treasure Valley; 211; emergency food assistance; clinics with sliding fee scales; emergency shelter; legal assistance; transportation assistance; crisis child care; elder care assistance; long term comprehensive care for people with disabilities.

Public Health District 5

(2018)

N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2017)

N/A - no response.

(2016)

1. Immunizations; Evidenced Based HV with Early Headstart; Health Promotions for PAN; partnership with health systems.

(2015)

In Gooding county: Low birthweight percentages are lower low smoking rates; low rates of excessive drinking; low percentage of low birth-weight babies; low breast cancer death rates; low melanoma death rates; low rates of poor physical and mental health days experienced; low asthma rates; low diabetes rates; low cancer death rates; low skin cancer death rates; low heart disease death rates; low respiratory disease death rates; low Alzheimer's death rates; low diabetes death rates; low rates of obesity; low rates of Sexually Transmitted Infections; low overweight/obesity rates; high rates of mammography screening; low rate of children living in poverty; high rate of access to recreational facilities. Other counties in the region experience: slightly higher rate of cancer deaths; high rate of lung cancer deaths; high rate of breast cancer deaths; high rate of prostate cancer deaths; high rate of respiratory disease rates; high rate of accident deaths; high rate of cerebrovascular deaths; high rate of Alzheimer's deaths; high rate of diabetes deaths; high suicide death rates; high rates of physical inactivity; high vehicle crash death rates; high teen birth rate; high rates of preventable hospital stays; low cancer screening rates.

Public Health District 6
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 6 exclusively.

(2017)
1. Healthy People 2020 goals met in the following areas: Death rate due to cancer, Death rate due to breast cancer, Death rate due to lung/bronchus cancer, Death rate due to prostate cancer, Adult obesity, Mothers who breastfeed, WIC participation is higher (42.7%) than the statewide average (32.5%).
2. Increasing physical activity; limiting access to prescription opiates; screening for HIV and providing access to HAART.

(2016)
1. Low HIV rates.
2. Adequate prenatal care; Power County low cancer rates; Franklin County COPD low rates; mothers who breastfeed.
3. * Just got a new seat belt and child safety seat use ordinance for the reservation.

(2015)
Slightly lower rates of asthma; lower binge drinking rates; slightly lower illicit drug use rates; higher rates of prostate screening; slightly lower rate of no dental visits. Low rates of binge drinking.

Public Health District 7
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 7 exclusively.

(2017)
1. * Partnerships with cities, communities, and businesses to increase healthy lifestyles. Increased breastfeeding rates. School-based immunization clinics; increasing adolescent immunization rates. Reduced foodborne outbreaks. Lower senior fall rates.

(2016)
1. Immunizations; Low teen birth rates; low tobacco use rates among adults and pregnant women; low HIV rates; adequate prenatal care; good breastfeeding rate; availability of crisis center in the region.

(2015)
In general, residents of Teton County are healthier than most of Idaho. Premature death rates are lower; obesity rates are lower; teen birth rates are lower; smoking; physical inactivity; and Sexually Transmitted; Infection values are lower; education metrics better than average in Idaho; mammography screening.

Based on the results of your most recent CHA, were there any populations, sub groups, or geographic areas prioritized? (examples: Hispanics, kids age <5, Clark County)

Statewide
(2018)
1. *Low income schools and seniors.
2. *Children, older adults, low socioeconomic status.

(2017)
1. Low income, minority.

(2016)
1. Children, especially 0-5, and the aging adult.
2. * Not currently, but partial focus of Safe Routes to School efforts on rural/ low income areas.
3. * Youth in rural areas.
4. * We recently introduced a senior food box program to better serve that population. We also have programs specific for children. We also utilize data showing food insecurity on the state and county level to help us target the needs of the area.

Public Health District 1
(2018)
1. Shoshone county, Benewah county, Low income individuals

(2017)
1. Mental health with the males.

(2016)
1. Adults with diabetes; areas with limited access to care; specifically mental health services.

(2015)
Adults who are obese and/or have diabetes; pregnant teens.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - no response.

(2016)
1. Behavioral health population.
2. * Native Americans.

(2015)
Adult persons who are obese and/or have diabetes; pregnant teens.

Public Health District 3
(2018)
1. Seniors, Hispanic community, rural and frontier communities.

(2017)
1. Homeless; children and adults; and migrant and seasonal farmworkers.
2. Hispanic communities; frontier communities; the uninsured.

(2016)
1. Hispanics; migrant and seasonal farm workers; homeless.

(2015)
Overweight/obese adults; those who have not graduated high school; unemployed; low income households; males 18-34 years; persons who do not engage in regular physical activity; tobacco users.

Public Health District 4
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 4 exclusively.

(2017)
1. Our CHNA data is stratified on 5 tiers of economic an 5 tiers of education levels.
2. Low income.
3. The health assessment surveyed Elmore County and five distinct sectors. Those sectors included schools, healthcare, businesses, community institutions, and county-level government.

(2016)
1. Low income; low education.
2. * Rural communities; refugees; child care providers.

(2015)
Young children; ages 18-64; income < $35,000; no high school diploma; adults; low income; individuals without a high school diploma; children in poverty.

Public Health District 5
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2017)
N/A - No response.

(2016)
1. Hispanic youth and childhood obesity primarily in Minidoka and Jerome Counties. Teen pregnancy rates in Twin Falls, Jerome.

(2015)
Uninsured; People with income level less than $15,000; Hispanics; Gooding County.; People with income level less than $35,000; Those with lower educational attainment (especially no high school diploma); Males 18-34.

Public Health District 6
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 6 exclusively.

(2017)
1. Oneida County: Ratio of primary care physicians to people is 1:4169 as compared to Bannock County at 1 primary care provider per 726 people. Access to care is a critical issue. The percentage of mothers who reported Medicaid as a payment source for prenatal care and/or delivery is significantly higher in PHD6 (52.7%) than statewide prevalence at 43.0% according to PRATS, 2015. Suicide risk among LGBTQ youth and adults.
2. * PLWH; aging adults.

(2016)
1. School based physical education; suicide prevention among faith-based organizations and LGBT community; access to healthy food options; low cost of unhealthy foods/drinks.
2. * American Indian.

(2015)
None were identified.

Public Health District 7
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 7 exclusively.

(2017)
1. * Children; Hispanics; Senior population; MSM; More Rural Counties in our district (Clark, Custer, Lemhi, Teton).

(2016)
Immunizations – children and adults; Hispanics; pregnant women; access to care in Clark County; people in poverty.

(2015)
Uninsured persons; low-income persons; and minority groups. Other 'vulnerable' populations included people who have no high school diploma; are unemployed; are severely work disabled; have major depression; or are recent drug users.

Please list specific factors your organization or agency identified in your CHA that contribute to greater health risks and poorer health outcomes for your patient population. (examples: availability of junk food, lack of school physical education programs, social determinants, high poverty rate, high obesity rates)

Statewide

(2018)
1. *Socioeconomic status and social determinants, rural access for Medicaid children or adults, Medicaid panels not accepting new patients and/or adult patients.
2. *Social determinants of health, high poverty rate, lower rates of educational attainment.
3. *Lack of money; inability to afford health insurance; cost of care; lack of transportation; inability to see dental providers who take sliding scale payments; inability to see dental providers who say they take Medicaid; limited or no access in rural areas; prioritization of medical needs over dental needs; lack of education about the importance of self-care.

(2017)
1. Obesity rates; drug abuse; access to care; social determinants of health.
2. * Lack of patient accountability in both wellness and management of chronic diseases. Employers, our physicians, and our health plan have a myriad of incentives to encourage members to alter lifestyle choices and behaviors, but patient engagement/accountability remains an issue.
3. Social determinants of health; lack of access to nutritious foods; lack of opportunity for physical activity; lack of health insurance coverage; rural populations.

(2016)
1. Social determinants; high poverty; drug tobacco and alcohol use; availability of junk food and soda.
2. * Lack of physical education in school; lack of physical activity throughout the day; community walk and bike ability; access to healthcare; availability of nutritious food versus junk food.
3. * Obesity and diabetes rates; weight and BMI; poor diets (intake of fruits and vegetables, esp.).
4. * Social determinants.
5. * Social determinants of health.
6. * Inconsistent availability of nutritious food; lack of health insurance preventing people from monitoring or managing their health.

Public Health District 1
(2018)
1. Limited access to care, stigma around mental health, physical location which increases access to substance abuse.

(2017)
1. Lack of access due to our rural setting and lack of mental health care providers.

(2016)
1. Barriers to accessing care; lack of mental health resources; transportation and health education.

(2015)
Long distances for health services; rural areas lack sidewalks; fitness centers/recreational areas.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - no response.

(2016)
1. High poverty rate; high suicide rate; high obesity.
2. * High poverty rates with reduced access to healthy foods. High obesity rates and a lack of nutritional knowledge.

(2015)
Heavy alcohol consumption and high access to liquor stores; above average population living in poverty; lower life expectancy; high tobacco use; low cancer screening rates; low socioeconomic status; poor nutrition and lack of physical activity; low quality of clinical care; high preventable hospital stay rates; long distances to health services; rural areas lack sidewalks; lack of fitness centers/recreational areas.

Public Health District 3
(2018)
1. Social determinants, lack of access to healthy foods, physical inactivity, high poverty rates.

(2017)
1. Lack of availability of nutritious food; high poverty rate; lower than average education level; high level of issues with health literacy; lack of transportation and lack of health insurance.
2. High poverty rates; high obesity rates; stigma around behavioral health; adverse childhood experiences; food deserts; low access to providers.

(2016)
1. Food deserts; lack of providers; poverty; ALICE population; lack of early childhood ed.; poor transportation
2. Poverty; lack of health insurance; cultural norms.

(2015)
Low rates of cervical and colorectal cancer screenings; low rates of mammography screenings; low college graduation rates; poor access to primary care and oral healthcare. High rates of unemployment; poverty/children living in poverty; percentage of single parent households; uninsured; aging population; unbanked and under-banked families; hypertension; high cholesterol rates. Prenatal care; access to healthcare services; mental health services; health insurance coverage medical home; physical activity; preventative medical and dental services; public transportation; access to healthy food options; poor nutritional habits; inadequate social support; high cost of dental health; a decrease in median household income.

Public Health District 4
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 4 exclusively.

(2017)
1. A. While our obesity rates are good compared to U.S. averages, they pose a gigantic health hazard. B. Prevalence of Mental illness and dearth of psychiatric providers. C. Impact of poverty. D. Lack of access and lack of health insurance. E. Excess alcohol consumption Not identified in our CHNA but know health issues include 1. Disengaged youth (youth who don't have relationships at school, in the community, and poor family dynamics). 2. Domestic violence and sexual abuse 3. A learned pattern of thinking that increases depression and anxiety.
2. Low income; poor diet; lack of exercise; isolation.
3. Unsafe and inconsistent built environment; Lack of after-school programming; Lack of physical activities in school programming; Lack of mental health resources; Stigma around mental health; Isolation among senior population; Lack of worksite wellness programs and initiatives in community institutions and businesses; Social determinants/high ALICE population.

(2016)
1. Obesity, although slightly lower than state average; high alcohol consumption; lack of access to psychiatric providers.
2. * Social determinants; high obesity rates; high tobacco rates (including e-cig use in youth); high poverty rates; lack of access to healthcare.

(2015)
Lack of: education support; prenatal care; physical activity; public transportation; providers accepting public insurance; screening programs; social support.

High percentage/rate of: hypertension; high cholesterol; suicide; children in poverty; preventable hospital stays; uninsured adults; poor mental health days; people living in poverty; unbanked and under banked families; mammography screening; high level of access to fast food. Decrease in median household income (with inflation adjustment lower than it was in 1980).

Public Health District 5
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2017)
N/A - No response.

(2016)
1. Access to healthy foods; demographic cultural norms; adequate access to parks; walking trails; exercise opportunities; access to mammography screening (no or under insured) as a result of transportation; continued use of cigarettes from youth (age in new consumers and age out of cessation participants).
2. Access to BH services for no or under insured individuals.

(2015)
Health indicators: Overweight/Obesity; high blood cholesterol; diabetes; fruit and vegetable consumption; low engagement in physical activity in both adults and teens; low colon cancer screening; high teen birth rates; high percentage of children living in poverty; high rates uninsured; high obesity rates; high rate of poor mental health days; high rates of preventable hospital stays; low access to primary care physicians; alcohol use; smoking.

Clinical Care: availability of primary care providers; chronic disease management; immunization programs; improved healthcare quality; integrated coordinated care; prenatal care programs; screening programs Social and Economic Needs: children and family services; disabled services; homeless services; job training services; senior services; veteran's services; violence and abuse services;Low health literacy.

Physical Environment: availability of recreation and exercise facilities; healthier air quality; water quality, etc. High alcohol and illicit drug use; high vehicle crash death rates; higher rates of overweight (but not obesity); mental illness; teen exercise; sexually transmitted infections; teen birth rate; smoking; accidents; breast cancer; cerebrovascular diseases; suicide. High alcohol and illicit drug use; high vehicle crash death rates; higher rates of overweight (but not obesity); mental illness; teen exercise; sexually transmitted infections; teen birth rate.

Public Health District 6
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 6 exclusively.

(2017)
1. Not having a regular source of care (primary care provider); Teenage alcohol use in PHD6 was 25%; Percentage of adults in PHD6 who engage I physical activity 150 minutes per week is 24.5%.
2. * lack of access to primary care; poverty; substance abuse; fragmented health information systems.

(2016)
1. High poverty rate; limited access to primary and specialty care; limited opportunities for active transportation and regular physical activity; food insecurity; limited access to preventive behavioral health services; easy access to firearms
2. Lack of health insurance and poverty; low rates of physical activity among school aged children; access to firearms; lack of access for behavioral health
3. * High diabetes; obesity rates; and substance use rates

(2015)
Lack of preventative care; limited financial resources within the community; delaying treatment until a problem has become severe; alcohol; drug; and tobacco use. Lowest life expectancy in state; high unemployment rate; physician shortage; low vegetable consumption; high levels of inactivity

Public Health District 7
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 7 exclusively.

(2017)
1. * Poverty rates; Lack of insurance; Rural areas; Transportation; Lack of walkable communities, especially in rural counties; Lower level of education; Access to inaccurate health information; Adverse childhood experiences (ACEs).

(2016)
High poverty rates; low education levels; lack of health insurance; lack of behavioral health resources for uninsured; built environment (lack of safe walking/biking paths); poor diets.

(2015)
Conclusions based on observations from Teton County compared to all other Idaho counties, in terms of health needs: low birth-weight births; excessive drinking; motor vehicle crash death rates; percentage of uninsured is very high; infant mortality; suicide; coronary heart disease rates; stroke rates.

Based on the results of your most recent CHA, please list the gaps in services, community resources, funding, etc., which your organization or agency have identified. (examples: no funding to support diabetes education, no local data on adolescents, etc.)

Statewide

(2018)

1. *Very little data on the elderly or adolescents to base programming on.
2. *Little funding to support youth tobacco prevention--much funding in the tobacco world goes to cessation.
3. *Not enough access to Medicaid dentists. Many "say" they take Medicaid, but either they aren't taking new patients, see a limited number of patients each month, have waiting lists that are months and months long (in some regions, an appointment can be scheduled almost a year out--that's not ok if you have pain now), or take one or two patients so they can be counted as a provider. Medicaid dentists who will see pregnant women or special needs adults are also hard to find. Refugee dental services are hard to find. Free clinics are rare outside the Treasure Valley.

(2017)

1. Lack of mental health care providers; tobacco/drug prevention/education.
2. * Lack of communication across the state; lack of disease specific funding; population specific data.

(2016)

1. Limited rural access to dental care; low-reimbursement by Medicaid; coverage gap for Medicaid in adults and seniors; lack access to data on hospital ED admissions/re-admissions for dental disease.
2. * Local level specific data (county).
3. * Diabetes education; wellness assessments; reimbursement through state Medicaid is very low. Variability in coverage for nutrition services by Idaho's major insurance companies. For example, some state employee plans do not cover nutrition services. Lack of data (weight, diabetes management, hypertension, etc.).
4. * Stigma attached to those with lung disease reduces awareness of need; hard to reach rural populations with programs and services.
5. * Access to care.
6. * Funding to support more collaborative efforts between healthcare providers and hunger relief organizations; funding to increase capacity for hunger relief.

Public Health District 1

(2018)

1. Limited funding to support mental health service, limited number of providers.

(2017)

1. Lack of mental health care providers.

(2016)

1. Limited mental health providers; limited diabetes treatment programs; lack of diabetes prevention programs.

(2015)

Physician and dental shortage areas; decreased funding in teen pregnancy prevention.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - no response

(2016)
1. Lack of providers overall, especially mental health providers. Lack of access to exercise opportunities in rural/frontier counties.
2. * We actually have great access to grants. It's difficult at times getting it dispersed to the masses.

(2015)
No palliative care; physician and dental shortage areas; decreased funding in teen pregnancy prevention.

Public Health District 3
(2018)
1. Low access to behavioral health services, services for rural and frontier communities, access to affordable/healthy foods, pre-K education.

(2017)
1. Lack of mental health services in our rural communities; No funding for CRC screening costs; Uninsured rate; inadequate funding for mammograms.
2. Large uninsured population; little incentive for affordable housing and affordable/healthy food; lack of transportation; coordination between members in the MHN.

(2016)
1. Little local mental health data; no crisis center; large uninsured and underinsured population; lack of affordable and healthy foods; lack of transportation resources for healthcare; funding for school-based services.
2. Funding for health insurance; lack of behavioral health services in rural areas; lack of specialty providers willing to see uninsured patients.

(2015)
Lack of the following: weight management programs; nutrition education; substance abuse services and programs; sex education; wellness prevention programs; education and access to preventive services; affordable health insurance; chronic disease management programs; mental health services; prenatal care; post-secondary education; community hubs; in-home service; central one-stop shop; communication of community resources; lack of public transportation; and basic lack of knowledge of available resources; education levels.

Public Health District 4
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 4 exclusively.

(2017)
1. Dental services for Medicaid; affordable behavior counseling; transportation to medical services; lack of funding to get low income; highly unhealthy people into lifestyle behavior modification programs.
2. Too many to list.
3. Mental Health services that are culturally-competent and accessible; No sustainable funding for afterschool programs across the county; Hispanic population needs the most services but less access due to scheduling conflicts, awareness, and language barriers; No youth-centered community institutions such as Boys & Girls Club, YMCA; Community engagement is lacking and funding streams are limited.

(2016)
1. Access for uninsured
2. * Community partners often don't know all of the resources that exist for patients. No local-level data on priority issues (only available at county level).

(2015)
Lack of access to: Mental health providers; affordable health insurance; job training services; nutrition education; affordable healthcare; behavioral health services; primary care provider; children and family services; healthy foods; healthcare services; mental health; health insurance coverage; affordable dental services; medical home; transportation to and from appointments; chronic disease management; Medicaid dentists; immunization education and low cost options; funding for transportation to Boise for specialty services; prenatal care 1st trimester; wellness and prevention programs; mammography screening.

Lack of: job training services; safe sex programs; Community hubs; In-Home Service; Central One- Stop Shop; recreational facilities; ability to advertise and increase community participation in education and physical activity programs; communication of community resources; public transportation; basic knowledge (i.e. available resources, education levels); nutrition education; substance abuse services and programs; tobacco prevention programs; publicizing current opportunities; creative wellness programs for young ages; consulting access for safety-net providers.

Public Health District 5
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2017)
N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2016)
1. It's not so much gaps as it is to coordinate and align community partners toward common goals. Many organizations cross over each other in service delivery without coordinating.

(2015)
Lack of funding for proper worksite wellness programs; there aren't enough providers in the community; no suicide hotline and staff aren't trained to address mental health problems; funding for a program that seemed to successfully help people stay on medications was dropped due to cuts in funding. No public transportation.

Public Health District 6
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 6 exclusively.

(2017)
1. Limited/no funding for suicide prevention. Need for additional behavioral health resources/regional crisis center. Lack of a functional Idaho Health Data exchange and inability of EMRs to interact with IDHE. (Regional data measurement not feasible at this time.) Improve access to physical activity opportunities. Need for improved school-based physical activity standards. Availability of affordable, nutrient dense foods. Need for discipline-specific suicide prevention education and public suicide prevention education.
2. * Access to primary care; access to exercise programs / facilities; access to behavioral health and substance abuse treatment programs.

(2016)
1. Limited funding to address heart disease; diabetes; suicide; and Rx drug abuse; extremely limited number of behavioral health providers; limited resources for care coordination.
2. Suicide prevention programs; diabetes programs; walkable cities; bike routes; affordable physical activity options; nutrition education.
3. Lack of behavioral health specialists; need for increased minimum standards for PE in schools in Idaho; lack of walking/recreational trails to support physical activity; need for suicide prevention training/education for gun shop owners/retailers.
4. *Funding.

(2015)
Mental health resources; resources for low-income families; affordable medications; home healthcare; psychiatric care across the lifespan.

Public Health District 7
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 7 exclusively.

(2017)
1. * No funding for some health education (food safety) No funding for colon cancer screenings or hepatitis C referrals. Limited medical and dental coverage and provider accessibility for seniors. Lack of affordable healthcare providers in the region (only 2 FQHCs, local public health). Lack of behavioral health services; substance abuse recovery services. Lack of affordable housing for families; lack of transitional housing. Lack of funding for some health education topics (food safety, for example).

(2016)
Lack of access to medical and dental care for uninsured; limited behavioral health providers/resources; lack of access to exercise opportunities in rural communities; transportation-especially in rural counties.

(2015)
The Teton Valley Healthcare CHA provided. Access full assessment here:
http://issuu.com/tvhealthcare/docs/tvhc_chna_complete

Based on the results of your most recent CHA, please list any assets and resources your health clinic or agency have identified that address health issues. (examples: state parks, bike paths, state cardiovascular program, local support for tobacco cessation)

Statewide

(2018)

1. *Health districts and the oral health program, the Idaho Oral Health Alliance and the Idaho Oral Health Networks in each area that convene local stakeholders, Head Start agencies and Idaho Stars program, United Way.
2. *Support for tobacco cessation and prevention programming, resources for asthma education, support groups for adults with lung disease, educational resources about lung disease and connection between clean air and lung health.
3. *Oral health integration into primary care settings would help address prevention; community water fluoridation would have a positive impact on reducing caries (cavities); medical-dental collaboration would likely help address opioid use; training on prevention and oral health education could help community health workers and community EMS workers with field triage and keep people out of the emergency departments.

(2017)

1. Free clinics; community health centers.
2. * Our community physicians are our best local resource. Collaborating with them through data sharing around cost and quality is our most effective asset.
3. * State CVD and Stroke programs, project filter, HEAL network.

(2016)

1. Dental home assignment for children under 5 enrolled in IdahoSmiles Plan (Medicaid)
2. * Bike lanes and walking paths; state heart disease and stroke prevention program; tobacco cessation support programs; healthy vending in public buildings.
3. * State diabetes and cardiovascular programs; Idaho HEAL.
4. * General support for tobacco prevention; DHW programs and resources; various coalitions.
5. * Increase the Department of Labor workforce recruitment and State loan repayment and forgiveness programs.
6. * Local clinics partnering with local food pantries.

Public Health District 1

(2018)

1. North Idaho's FQHC's, University's, Regional Behavioral Health Board, Community collaboration on our Opioid issue.

(2017)

1. Bike Paths, Boundary Community Hospital; University of Idaho Extension Office; Kootenai National Wildlife Refuge; Elk Mountain Farms; Boulder City Ghost Town; Kootenai Tribal Sturgeon Hatchery; Naples General Store/American Youth Hostel; Law Enforcement/Volunteer Fire/EMS; Outdoor Recreation; Spiritual Health; Local Media; Libraries; Safe place for kids; Community Activities; Farmer’s Market; Fishing/Hunting; Parks/Reservoirs; Historic Sites/Museums; Arts/Theatre; Agriculture.

(2016)

1. Community gardens; WIC programs; outdoor recreation (trails and bike paths); higher education; libraries.

(2015)

Many resources are listed for each county which include hospital/clinic locations 'things to do and see,' but they are not tied to health issues.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - no response.

(2016)
1. A community that cares; SRCC; ACE's training; Partnerships; Communication network.
2. * We have a grant that helps with tobacco cessation. We have two grants for diabetes.

(2015)
Twenty-four (24) pages of local resources provided to address each prioritized issue; the majority are hospital/clinic facilities and local community-based organizations. Fifteen page (15) resource compendium provided in appendix was created as resource to address identified health priorities. Many resources are listed for each county which include hospital/clinic locations, 'things to do and see,' but they are not tied to health issues. Each county page has extensive list of some hospital/clinic resources along with list of 'things to do and places to see,' but not tied to health issues. Additional resources noted include: Public Health Department; Federally Qualified Health Centers; Community Clinics; Veterans Administration; HIS.

Public Health District 3
(2018)
1. Faith based community organizations, local parks, CHWs, senior centers, walking paths, U of I extension office, farmers market, WICAP, food pantry, Meals on Wheels, gyms, Boys and Girls Club, FQHCs.

(2017)
1. We are a fully integrated care system providing medical, dental and behavioral health services in most of our clinics. The communities we serve typically have several parks that are accessible to local residents, our communities also have fairly good access to public health district services.
2. Provider education programs (opioid, cancer, diabetes); care coordination directory; tobacco cessation; WIC; family planning; behavioral health board; Women's Health Check; community advisory councils (in progress).

(2016)
1. Health promotion programs; SHIP; multiple points of contact with people (EH, FHS, NHP, etc); local presence.
2. We have some funding for uninsured patients We are moving to an integrated, one-stop-shop clinic model - medical/behavioral health/dental.

(2015)
Abuse/violence advocacy & services; after school programs / youth mentoring; at-risk youth services; behavioral health and substance abuse services; childcare; chiropractic services; dental services; disability services; educational services; government contacts; homeless services; housing services; hospice services; hospitals; legal services; low income medical resources; nursing homes; public health resources and referral and miscellaneous; services; refugee services; senior services; veteran services;Gem County Health Connection; Gem Economic Development Assoc.; 1, 3, and 5 year action plan of activities and a sustainability plan through IPAN; utilize the Change Tool to support and implement programs and policies; full time advanced EMS; No Sun For Baby class; Look Good Feel Better; Smart 911 education; tobacco cessation; community sharps collection; car seat distribution; CPR class; mammogram promotions; prescription medication drop-off; School Improvement Management Systems training; colon cancer awareness; prenatal classes; Walter Knox Memorial Hospital Health and Safety In The Sun.

Public Health District 4

(2018)

N/A - there were no responses from organizations or agencies who serve Public Health District 4 exclusively.

(2017)

1. Valley County is the healthiest county in Idaho and it's fair to say we have cultivated a culture of health with many assets and organizations working together to create this culture. We have a remarkable bike and pedestrian trial system, miles of Nordic skiing, the amazing Ponderosa State Park, our Chamber of Commerce's mission statement includes providing for community wellbeing. We have a devoted non-profit sector working together to strengthen outcomes and resources. We could write pages about our resources and assets, and our determination to make the social and physical environment more health conducive.
2. Too many to list.
3. Local FQHC, hospital, public health, and other health organizations; One of the school districts.

(2016)

1. Access to natural environment. Excellence state and local parks. A city and county government that believe in and promote health. A county wide coalition that promotes health.
2. * Free tobacco cessation classes. Focus on sustainable environmental and policy changes. SHIP project and creation of the Central Health Collaborative. Focus on the medical-health neighborhood. Academic detailing for pre-diabetes, diabetes, and hypertension.

(2015)

Adequate senior services; high level of flu and pneumonia immunizations; Boise State University; branch location for other universities; outdoor activities; colleges Northwest Nazarene University; College of Western Idaho; Hispanic Cultural Center; education and exercise opportunities but people are not aware. YMCA; Boise VA Medical Center; safety-net clinics; sliding fee scale providers.

Public Health District 5

(2018)

N/A - there were no responses from organizations or agencies who serve Public Health District 5 exclusively.

(2017)

N/A - No response.

(2016)

1. Health in All Policies; MF for tobacco cessation; Board of Health funding for counties not covered by the MIECHV sub-grant for Home Visits and early intervention; expansion of success with Let's Move initiatives.

(2015)

1. Implement Intermountain’s diabetes education/lifestyle coaching program to help improve the health of people identified as at-risk for diabetes referred by Family Health Services Clinic; provide additional community education and diabetes education events to help promote awareness of diabetes in the Cassia community. There is a large list of resources available in the North Canyon CHA … too many to list here and it is not obvious to me which should be included here and which should be left out. See North Canyon CHA for the list if needed.
2. Intermountain provided $7.6 million in charity care for low-income mental health patients (defined as Medicaid/uninsured with mental disorders and / or substance abuse issues) in more than 2,700 cases in 2012;
3. Collaborative partnerships exist in all urban communities to link uninsured people with community-based behavioral health providers;
4. Intermountain provides grants to Community Health Centers and safety net clinics of $2.3 million annually for comprehensive health services inclusive of mental health. A list of resources is identified beginning on page 135 of the health needs assessment. A list of resources is identified beginning on page 133 of the health needs assessment.

Public Health District 6
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 6 exclusively.

(2017)
1. Portneuf Greenway Outdoor recreational opportunities (biking, skiing, hiking, hunting, etc.); Community Fun Run Series; City parks, state parks and monuments; Suicide Prevention Action Network and other non-profit, health enhancing programs; Problem-solving courts (Mental Health Court, Substance Abuse Court, etc.); Issue-specific support groups (AA, bereavement support groups, Mended Hearts, etc.); Community gardens; Public Libraries.
2. * Federal grant funding: Ryan White III, HRSA / Title 7, Health professions education programs.

(2016)
1. Building walkable/bikeable infrastructure; especially in rural areas; food banks; WIC.
2. Heart disease and diabetes program. Physical activity and nutrition program. Relationships with community partners.
3. Tobacco use prevention and cessation; immunization clinics; excellent community partnerships; Women's Health Check; Parents as Teachers Program; WIC; family planning; emergency preparedness; licensed child care facility inspections; environmental health services; dental fluoride and sealants; cancer prevention and screening; worksite wellness support; Fit and Fall Proof.

(2015)
Very few specific resources were identified except Bingham Memorial Hospital; chiropractors; naturopaths; nursing homes; free clinic; and specialists such as ENTs and orthopedics.

Public Health District 7
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 7 exclusively.

(2017)
1. * Local support for tobacco cessation. Patient assistance programs for immunizations. Partnership with community groups who provide funding for healthcare services (mammogram, HIV services, fall prevention, immunizations, children's oral health).

(2016)
Behavioral Health Crisis Center in the community; free tobacco cessation classes; WIC program; immunization clinics (some free ones to support under- and uninsured individuals); Parents as Teach Program; community partnerships/ coalitions; fluoride varnish and sealant services for children; Risk Reduction programs for youth; Fit & Fall Proof program; creation of the regional health collaborative through the SHIP program; community health resource directory.

(2015)
There were many resources listed beginning on page 29 of the CHA. Access full assessment here:
http://issuu.com/tvhealthcare/docs/tvhc_chna_complete

What data were used to develop your latest CHA? (examples: education data, Behavioral Risk Factor Surveillance System (BRFSS), Census, county health rankings, health needs survey, focus groups)

Statewide
(2018)
1. *Smile Surveys, Community Assessments by the United Way, ALICE reports, education data, BRFSS.
2. *State and national prevalence data, community needs assessments, focus groups, program evaluation feedback.
3. *We rely heavily on data offered by the Idaho Oral Health Program including BRFSS, Smile Survey, Oral Health Burden Report.

(2017)
1. * We have several predictive analytic tools which identify both medium to high risk profiles (likelihood of ER or inpatient visit within the next 6 months), but all data is based on what physicians and hospitals identify and code/bill which is submitted to us. We use a risk-adjustment software (Verisk) to assist us in identifying risk factors.
2. * National data resources, BRFSS, county health rankings.

(2016)
1. Smile Survey; BRFSS; census
2. * BRFSS; YRBS; County health rankings; population health data; community commons assessment; national impact data; health needs data; all available data sources
3. * Not applicable to our organization as a whole. Applicable to individual RDNs depending on where they are employed. District health departments (WIC) use data; State WIC; State Child Nutrition Programs; University of Idaho Extension - Eat Smart Idaho (formerly SNAP-Ed).
4. * Population health needs surveys from area health systems; BRFSS; YRBS; ATS; census; focus groups; CDC data; etc.
5. * Educational data.

Public Health District 1
(2018)
1. Community Commons, County Health Rankings, BRFSS, YRBS, Community health needs survey, interviews.

(2017)
1. BRFSS; County Health rankings; survey.

(2016)
1. BRFSS; County Health Rankings; Vital Statistics; IDOL Idaho Primary Care Physicians Workforce Overview; 2013 Idaho Dentists and Dental Specialists Workforce Supply and Demand Summary; Network of Care; Idaho; SPAN Idaho October 2012 Suicide Fact Sheet; US Census.

(2015)
County Health Rankings; National Vital Statistics System-Mortality (NVSS-M); U.S. Census; Advisory group from PHDs 1 & 2.

Public Health District 2
(2018)
N/A - there were no responses from organizations or agencies who serve Public Health District 2 exclusively.

(2017)
N/A - no response

(2016)
1. BRFSS; Vital Stats (ID and WA); CHR; PH-INCD CHA; focus groups; National Information Center for Higher Education; US Census Bureau; The State of Preschool; United Way ALICE report; Community Action Partnership.
2. * Surveys; education data; our medical software (RPMS/EHR).

(2015)
County Health Rankings; communityhealth.hhs.gov; Truven Market Planner; getpalliativecare.org; caringinfo.org; healthmetricsandevaluation.org; UWPHI county Health Rankings; BRFSS; NVSS-M; U.S. Census; population health needs survey; focus groups.

Public Health District 3
(2018)
1. BRFSS, Census, ACS, WISPr, PRATS, County Health Rankings, Kids Count Data Center, YRBS, Idaho Dept of Ed Report Card, National Survey of Drug Use and Health (SAMHSA), IRIS.

(2017)
1. Data is gathered utilizing Community Commons, policy mapper, and UDS mapper. Each of these is a compilation of several data sources.
2. BRFSS; census; focus groups; survey; school data; crime data; vital stats; CDC; Kids Count; IRIS; American Community Survey.

(2016)
1. American Diabetes Association; KIDS COUNT Data Center; BRFSS; National Environmental Public Health Tracking Network; County Health Rankings and Roadmaps; Map the meal gap; Idaho 3rd grade body mass index (BMI) assessment; Population receiving food stamps; Idaho reportable disease summary; Idaho HIV-AIDS and STD statistics; Get healthy Idaho: Measuring and improving population health; Vital Statistics; Pregnancy Risk Assessment Tracking System (PRATS); Idaho's Immunization Reminder Information System (IRIS); Idaho School report card; Idaho Youth Risk Behavior Survey - A healthy look at Idaho youth; Crime in Idaho database; National Center for Education Statistics; National Survey of Drug Use and Health; ALICE: Asset limited, income constrained, employed; American Community Survey; U.S. Census Bureau; U.S. Department of Agriculture; Food Access Research Atlas.

(2015)
BRFSS; IDHW Vital statistics; Community Health Needs Rankings; Key informant interviews with local organizations and leaders; University of Wisconsin Population Health Institute; www.census.gov; County Health Rankings; Outdoor activities; colleges/universities: Northwest Nazarene University; College of Western Idaho; Boise State University; Hispanic Cultural Center; United Way; University of Wisconsin Population Health Institute; Robert Wood Johnson Foundation.

Local school district data.

Public Health District 4

(2017)
1. We collect vital statistics from a number of sources and compile it with qualitative data from interviewing 28 local community health experts.
2. BRFSS, Vital Statistics, CDC, Alzheimer's Assoc, Athritis foundation, Bureau of Labor Statistics, Comprehensive Cancer Alliance, County Health Rankings, America's Health Rankings, EPA, U.S. Census Bureau, too many to list.
3. The assessment used qualitative and quantitative data through interviews using the CDC CHANGE Tool.

(2016)
1. Interviews with 20+ local health experts. The St. Luke's methodology and resources spent compiling CHNAs has been described as the gold standard by national authorities on CHNA.
2. * BRFSS. YRBS. Census data. County Health Rankings. CHNAs prepared by local hospitals. ALICE Report from the United Way.

(2015)
County Health Rankings; United Way; Saint Al's; expert interviews; University of Wisconsin Population Health Institute; Youth Risk Behavior Surveillance; affected population surveys; Idaho Economics; the Robert Wood Johnson Foundation; Local school district data; County

Health Rankings; United Way; Saint Al's; expert interviews; University of Wisconsin Population Health Institute; Youth Risk Behavior Surveillance; Affected population surveys; Idaho Economics; exercise facilities

Public Health District 5

(2017)

(2016)
1. BRFSS; CHR; local surveys; Network of Care data; YRBSS; PRATS; HP 2020; SLHS (Magic Valley, Jerome, WR) CHNA; SPAN; CDR of Idaho; Intermountain Health System (Cassia); CDC; Vital Stats.

(2015)
BRFSS (Idaho and Utah); Focus group data (primary data); US Census Data (ESRI, 2012 source); County Health Rankings; Idaho Vital Statistics; Affected population surveys and focus groups; In-depth interviews with community leaders

Public Health District 6

(2017)
1. County Health Rankings; Census; BRFSS; Gateway to Health; PRATS; State of Idaho Vital Statistics; Network of Care; IDHW; Years Per Life Lost (YPLL); HP2020; Emergency Department Reports.
2. * Health department data; clinical performance measures; grant program data.

(2016)
1. Vital Stats; BRFSS; County Health Rankings; focus groups
2. BRFSS; County Health Rankings; YRBSS
3. Regional hospital data; County Health Rankings; US Census; Network of Care; Idaho Vital Statistics; BRFSS;
4. *BRFSS

(2015)
Idaho BRFSS; Idaho Vital Records; One-on-one interviews and focus groups with healthcare providers and administrators; Interviews and focus groups with community stakeholders; Census; Vital Statistics Bureau, DHW; Network of Care; County Health Ranking

Public Health District 7

(21017)
1. * BRFSS YRBS Vital Stats; High-risk reports on WIC participants; Idaho Immunization Program reports; CDC; National Immunization Survey.

(2016)
BRFSS; Community Health Rankings; PRATS; Vital Stats.

(2015)
County Health Rankings; www.communityhealth.hhs.gov; Truven Market Planner; www.capc.org; www.getpalliativecare.org; www.caringinfo.org; iweb.nhpco.org; www.healthmetricsandevaluation.org; www.dataplace.org; www.cdc.gov; www.CHNA.org; www.datawarehouse.hrsa.gov; www.worldlifeexpectancy.com/usa-health-rankings; community and healthcare surveys;

Acronym Dictionary

1305 – Shorthand for the federal grant titled "State and Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health". 1305 is the federal grant number.

ADA / AADE – American Diabetes Association / American Association of Diabetic Educators

BRHPC – Bureau of Rural Health and Primary Care.

CDC – Centers for Disease Control and Prevention

CHEMS – Community Health Emergency Medical Services

CoIIN – Collaborative Improvement and Innovation Network to Reduce Infant Mortality

CY – Calendar Year, January 1 through December 31

DPH – Division of Public Health

DPP – Diabetes Prevention Programs

DSME – Diabetes Self-Management Education

DPRP – Diabetes Prevention Recognition Program

EMS – Emergency Medical Services

IAEYC – Idaho Association for the Education of Young Children

IDHW – Idaho Department of Health and Welfare

IHC – Idaho Healthcare Coalition

ISU – Idaho State University

NRT – Nicotine Replacement Therapy

PCMH – Patient Centered Medical Home

PHD – Public Health District

RC – Regional Health Collaborative

SHIP – Statewide Healthcare Innovation Plan

SFY – State Fiscal Year, July 1 through June 30

WHCRT – Women's Health Check Real Time database

WIC – Special Supplemental Nutrition Program for Women, Infants and Children

WISPr – WIC Information System Program